



CARDIAC RISK ASSESSMENT

Note: This information will be kept confidential and read by Challenge Northwest staff only.
Please complete this form, the participant medical information, and liability document now and send it to us or bring the completed forms with you on your challenge course date. Our Address: Challenges Northwest Inc. 36003 S.E. 94th Place, Snoqualmie, Washington 98065

NAME _____ Birth date _____
SEX Male / Female Height _____ Weight _____

Medical History: Do you have any of the following symptoms or conditions?
(Circle yes or no)

| | | |
|---|-----|----|
| Do you have any history of heart disease or heart attack? | yes | no |
| Do you have any history of high blood pressure? | yes | no |
| Do you ever have chest pains or palpitations? | yes | no |
| If yes: Have you seen a doctor about these symptoms? | yes | no |
| Are they associated with shortness of breath? | yes | no |
| Are they associated with sweating or anxiety? | yes | no |
| Have you ever had a stroke? | yes | no |
| Do you have diabetes or elevated blood sugar? | yes | no |
| Have you ever had your blood lipids checked? (blood lipids are cholesterol, triglycerides, LDL, HDL) | yes | no |
| If so, were they elevated? | yes | no |
| Is there a family history of heart disease? | yes | no |

If you circled "yes" to any of the above, please explain below:

Issue: _____

Explanation: _____

Issue: _____

Explanation: _____

(Use reverse side if necessary to describe further issues.)

Social History: Describe briefly your use of the following:

Tobacco: packs per day _____, times years _____, date quit _____

Alcohol: type and amount _____

Caffeine: cups per day _____

Please describe your exercise routine and general level of fitness: _____
