SEMPER FIT CENTER

PERSONAL FITNESS ASSESSMENT APPOINTMENT

SEMPER FIT
MCCS FITNESS CENTER
Marine Corps Air Station Miramar

APPOINTMENT INFORMATION

MicroFit Assessment Fees are $15.00 per assessment. Active Duty personnel are free.

THE FOLLOWING AREAS WILL BE ASSESSED DURING YOUR APPOINTMENT

- Health/Medical History Profile
- Resting Blood Pressure and Heart Rate
- Body Weight and Composition
- Cardiovascular Fitness
- Muscular Flexibility
- Muscular Strength

INSTRUCTIONS IN PREPARATION FOR THE FITNESS ASSESSMENT

1. If you will be late or have to cancel, please call **(858) 577-4654** no later than 24 hours prior to your appointment.
2. Please dress in athletic clothing. Shorts, a short-sleeved T-shirt and rubber-soled shoes are best. Do not wear tights or one-piece leotards since they make it difficult to obtain accurate body fat measurements.
3. <u>Abstain from tobacco, alcohol, caffeine and large amounts of food at least 3 hours prior to testing.</u>
4. Take your regular daily medication. If you are presently taking blood pressure or heart medication, please notify the staff at **577-4654** prior to your appointment.
5. <u>Abstain from vigorous physical exercise at least 4 hours prior to your appointment.</u>
6. Try not to schedule your Personal Fitness Assessment immediately after a major change from your daily routine such as a long business trip, infectious illness or several nights of less than normal sleep. These events have a short-term effect on your metabolism and may cause false test results.
7. You will not be tested if you are feverish or feeling ill.

INFORMED CONSENT FOR EXERCISE TESTING AND EXERISE PRESCRIPTION (11/06)
Marine Corps Community Services, Marine Corps Air Station Miramar
MCCS Fitness and Wellness Program

Prior to exercise testing and exercise prescription, a health/medical history questionnaire will be completed to determine any contraindications for exercise testing and prescription. Testing will consist of a blood pressure and resting heart rate check, body fat measurements using skinfold calipers, a cardiovascular test using a sub-maximal test protocol on a bicycle ergometer, flexibility assessment using the sit and reach test, and a muscular strength assessment by exerting force on a static bar to determine biceps strength. The cardiovascular test will have a warm-up period to gradually elevate the heart rate, a period that will maintain the heart rate between 60 to 80 percent of predicted maximum heart rate, and a cool-down period for gradual decrease of the heart rate.

Exercise prescriptions will be designed to improve and/or maintain flexibility through stretching exercises, muscular strength and endurance through weight training or floor exercises, and cardiovascular fitness through cardiovascular exercise (activities that use larger muscle groups in a rhythmical manner and increase the heart rate).

During exercise testing and prescription there exists the possibility of experiencing discomfort that includes but is not limited to abnormal heartbeat, abnormal blood pressure response, various muscle and joint strains or injuries, and in rare instances, heart attack. Every effort will be made to minimize these through preliminary examination of the health/medical history questionnaire and by observations during testing. Any exercise program will have a risk of various muscle and joint strains or injuries or any other illness or soreness. The risk of these types of injuries or illnesses will be minimized by providing a safe workout environment with instruction on proper use of the equipment, and an exercise prescription recommending a gradual increase in exercise intensity.

The information based on the observation made during the exercise testing and exercise sessions will be treated as privileged and confidential; however, it may be used for statistical purposes with your right of privacy retained.

You may refuse to participate now or stop at any time during the exercise testing or the exercise sessions. Before signing this form please feel free to ask any questions regarding any aspect of this program which is unclear to you and we will answer these questions to the best of our ability.

After reading the preceding statement and having had any and all questions answered to my satisfaction I certify that I am sufficiently fit to attempt the test and exercise program and agree to participate with full knowledge, understanding, and appreciation of the risk therein. I recognize the risks of illness and injury inherent in any exercise testing and exercise program and I am participating upon the express agreement and understanding that I, for myself, my heirs, and executors, assume these risks and hereby waive and release the United States Government, United States Marine Corps, Marine Corps Community Services, Marine Corps Air Station Miramar, and all their agents or employees, from and against any and all claims, costs, liabilities, expenses or judgments arising out of my participation in such exercise programs; and hereby agree to indemnify and hold harmless the United States Government, United States Marine Corps, Marine Corps Community Services, Marine Corps Air Station Miramar, and all their agents or employees from and against any and all claims, damages, liabilities or causes of action, arising out of my participation in such an exercise program.

Signature: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________

MCCS PERSONAL FITNESS ASSESSMENT

Marine Corps Air Station Miramar
Health/Medical History

PERSONAL INFORMATION

Name (Last, First, MI)

Status: (Check)

❑ Active Duty ❑ Reserves ❑ Retired ❑ Dependent ❑ DOD

Age	Birth Date	Sex		Rate/Rank
Command/Station			Home Phone No.	Work Phone No.

Occupation

Address

Physician's Name

Physician's Address	Phone No.

Physical Activity Readiness Questionnaire (PAR-Q)

Please read the questions carefully and circle "YES" or "NO".

1. Has your doctor ever said you have heart trouble?	YES	NO
2. Do you frequently have pains in your heart and chest?	YES	NO
3. Do you often feel faint or have spells of severe dizziness?	YES	NO
4. Has a doctor ever said your blood pressure was too high?	YES	NO
5. Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise, or might be made worse with exercise?	YES	NO
6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?	YES	NO
7. Are you over age 45 and not accustomed to vigorous exercise?	YES	NO

HEALTH/FITNESS HISTORY

1. Are you presently involved in a regular exercise program? *(please circle)* YES NO

Type of Exercise	*Duration*	*Frequency*	*Intensity*	*Date Started*

2. Do you now or have you ever smoked tobacco? *(please circle)* YES NO
   (a) If you previously smoked tobacco: How many years? ________ How often? ________
   When did you quit? ________
   (b) If you currently smoke tobacco, how much? ________

3. Do you drink alcohol? *(please circle)* YES NO
   (a) If yes, how much per day? ________ How much per week? ________

4. Do you drink coffee or cola's with caffeine? *(please circle)* YES NO
   (a) If yes, how much per day? ________

5. Are you now or have you ever been on a diet? *(please circle)* YES NO
   (a) If yes, please explain: ________

6. Do you consider yourself overweight or underweight? *(please circle)* YES NO

7. How many meals do you usually eat per day? ________

8. Do you usually eat breakfast? *(please circle)* YES NO

9. How many times per week do you usually eat the following? Beef ________ Fish ________
   Pork ________ Fowl ________ Eggs ________ Fast Foods ________ Desserts ________

10. Do you regularly use any of the following? *(please circle)*
    Butter Sugar Sweeteners Whole Milk Salt

11. How active do you consider yourself? *(please circle)*
    Sedentary Lightly active Moderately active Highly active

12. How would you describe your nutrition habits? *(please circle)*
    Good Fair Poor

13. How would you characterize your life? *(please circle)*
    Highly Stressful Moderately stressful Low in stress

14. Please describe your knowledge of exercise and fitness? *(please circle)*
    Good Fair Poor

15. Please describe your knowledge of nutrition? *(please circle)*
    Good Fair Poor

MEDICAL HISTORY

1. Check "YES" or "NO" for any conditions or diseases you now have or had in the past.

	YES	NO		YES	NO
Heart Attack			Emphysema		
Coronary bypass			Bronchitis		
Cardiac surgery			Pneumonia		
Diabetes			Chronic recurrent cough		
Stroke			Increased anxiety or depression		
Peripheral vascular			Emotional disorders		
Phlebitis or emboli			Fatigue or lack of energy		
Rheumatic fever			Trouble sleeping		
High blood pressure			Migraine or recurring headaches		
Low blood pressure			Swollen, stiff, or painful joints		
Chest discomfort			Foot problems		
Extra, skipped or rapid heart beats			Knee problems		
Heart murmurs			Back problems		
Ankle swelling			Shoulder problems		
Unusual shortness of breath			Neck problems		
Light-headedness or fainting			Broken bones		
Epilepsy or seizures			Ulcers		
Anemia			Stomach or intestinal problems		
Asthma			Hernia		
Hypoglycemia			Limited range of motion in joints		
High cholesterol			Arthritis		
Abnormal ECG/EKG			Bursitis		

a. Any other health problems? Please list. ______________________________

____

b. If you indicated "YES' to any of the above, please explain briefly, date of onset, whether medical advice was sought, and result of evaluation: ______________________________

____

____

MEDICAL HISTORY - PART 2

2. Please list any prescribed medications you are now taking.

3. Please list any over-the-counter medications or dietary supplements you are now taking.

4. Please list any illness, hospitalization, or surgical procedure within the past two years.

5. Please list any drug allergies.

6. Please list date of last physical examination and results.

7. Are you pregnant? *(please circle)* YES NO
   (a) If yes, which trimester? ______________________

FAMILY HISTORY

Please list all immediate family members who now have or have had a history of heart disease, strokes, high blood pressure, or diabetes:

Relationship	Type of disease	Age of diagnosis	Age at death

FITNESS GOALS

Please list specific goals:

Signature ______________________ Date ____________

Staff Signature ______________________ Date ____________