



# ANTENATAL PRESCREEN MEDICAL QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential .

<b>A. PERSONAL INFORMATION</b>	
Name:	
Address:	Postcode:
Telephone Number:	
Mobile Number:	
Email:	
Name of Doctor:	Doctor's Telephone Number:
Emergency Contact Name and Telephone Number:	
Ante Natal	Post Natal:
Due Date:	
Current Weight:	Weight Prior to Pregnancy:

<b>B. PERSONAL HEALTH HISTORY</b>
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<b>Please list any past medical problems diagnosed</b>

<b>Exercise</b>	Did you exercise regularly prior to becoming pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you exercised during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Please provide details.

Is this your first Pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever suffered miscarriage in any previous pregnancies, vaginal bleeding or other complications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, please provide details.

Is your pregnancy going well - are you having any medical treatment for complications in your pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, please elaborate below.

Please answer the following carefully

Do you or have ever you ever been diagnosed with any of the following:

1. Symphysis Pubis Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Serious heart, respiratory, renal or thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Type 1 or Type 2 diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Anaemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Swelling in hands, ankles or face	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. High or Low Blood Pressure - Preclampsia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Urinary tract, bladder or kidney infection – in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Do you suffer any problems in controlling urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Have you been diagnosed with extreme obesity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Are you on any medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you answer yes to any of the questions detailed above, please provide details.		

**PLEASE NOTE: You must agree to the client disclaimer below before participating in our classes. Please read and tick in the box provided before participation in the classes.**

Every precaution will be taken to ensure your safety during participation in these classes. With that in mind, you are aware of the nature of the classes and any risks involved. You acknowledge that certain elements of the classes will be physically demanding. You agree that you are physically capable of participating in the sessions and accept full and complete responsibility for your own participation in the class. You agree that should any medical or physical problem arise prior to or during a class which is likely to affect your ability to participate in a class, you will withdraw from the session. FitBack & Bumps Ltd and your Physiotherapist Instructor shall not be liable to you for any indirect or consequential loss or damage including loss of earnings arising out of your participation in classes. If there is anything else we need to know regarding your health & fitness, please provide details above in the Prescreen Medical Questionnaire.

**I agree to the terms and conditions stated above**  Please tick

Signed (Participant) \_\_\_\_\_ Date: \_\_\_\_\_