

PRINT & THOROUGHLY READ THESE DOCUMENTS

Please review the information below, to ensure you are prepared for your assessment.

- **NO SHOWS & CANCELLATIONS LESS THAN 24 HRS, WILL BE CHARGED \$50.00.**
- **Spectators & CHILDREN are NOT allowed in the lab. Please make child care arrangements!**

Preparing for Your RMR Assessment

To ensure that your RMR assessment is as accurate as possible, there are a number of guidelines you need to follow. Please follow the recommendations given below before your assessment:

1. Dress comfortably.
2. Please reschedule if you have an upper respiratory infection or related health concern.
3. Don't eat or drink (except water) for at least 8 hours prior to your assessment.
4. Don't engage in any strenuous exercise the day before the test and avoid physical activity on the day of the test.
5. If you take insulin, do not take your morning dose until after your test. Take all other medications as usual. Bring all your medications with you to the test
6. You will be required to fill out a Health History form. (attached....please bring it with you)

PARTICIPANT INFORMATION & HEALTH HISTORY FORM

All information given is personal and confidential. The information will enable us to determine clearance to participate in activity. Participant takes full responsibility to any inaccurate information given.

NAME: _____ SEX M F
Date of Birth ___/___/___ Age: ___ Weight **ACCURATE:** ___ Height _____
Address: _____ CITY _____ ZIP _____
Phone: __ (____) _____ Home Work Mobile
Email: _____ @ _____ ● _____

EMERGENCY CONTACT: _____

Please circle 'yes' or 'no' All information is confidential.

1. Do you have known heart, vascular, lung, liver, kidney or thyroid disease?? ___No ___Yes, explain _____
2. Do you ever experience: (check applicable box) shortness of breath dizziness or fainting
difficult, labored or painful breathing irregular rapid pulse or heart rate
pain, discomfort, tightness or numbness in the chest
3. Are you currently taking medication? ___No ___Yes, list & explain _____
4. Have you ever been diagnosed with or had/have the following? (circle only those that apply)
heart attack angioplasty heart surgery coronary artery disease
angina hypertension heart murmur asthma emphysema
bronchitis stroke anemia cancer osteoporosis
seizures arthritis eating disorders epilepsy hepatitis
blood disease bone or joint injuries high blood pressure high cholesterol
allergies diabetes
Others not listed: _____
5. Have your first-degree relatives (parents, sisters, brothers, or children) developed heart disease or died at an early age (before 55 if male; before 65 if female)? ___No ___Yes
explain _____
6. Do you smoke? ___No ___Yes
7. Do you have a sedentary lifestyle? ___No ___Yes
8. Are you or "could" you be pregnant? ___No ___Yes
9. Are you breast feeding? ___No ___Yes
10. Are you menstruating today? ___No ___Yes
11. Do you take ephedrine or any other supplement? ___No ___Yes list _____
12. Are you currently under medical care? ___No ___Yes, explain _____
13. Do you know of any other reason why you should not do physical activities? ___No ___Yes, explain _____

My Signature certifies that all of the above is true.

Participant: _____ Date _____

RETURN @ Scheduled Test Time