

ANTE NATAL PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

Regular physical activity is fun and healthy and increasingly more women are starting to become more active both during and following pregnancy. Being active is very safe for most people, however, we recommend that you should check with your doctor before becoming much more physically active during pregnancy.

Common sense is your best guide. Please read the questions carefully and answer each one honestly. All answers will be treated with the strictest confidence. Please tick YES or NO:

YES **NO**

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your doctor ever said that you have a heart condition? If YES, please give details. _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you feel pain in your chest when you do any physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. In the past month, have you had chest pain when you are not doing physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you lose your balance because of dizziness or do you ever lose consciousness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a back/pelvic or other joint problem that could be made worse by a change in your physical activity? If YES, please give details. _____
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you suffer from raised blood pressure? If YES, is this pregnancy related and how is it being treated? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you suffer from diabetes? If YES, is it pregnancy related and how is it being treated? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you know of any other reason that could affect your participation in exercise?
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you suffer from asthma? If YES, how do you control it? _____
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you suffer from any other conditions that may affect you during participation? E.g. heartburn, nausea, soreness or muscle aches. If YES, please give details.
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you/were you a regular exerciser? If YES, please give details.
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you do/intend to do any other exercise in addition to this programme?
_____ |
| | | 13. Which hospital is looking after you? _____ |
| | | 14. Please state your anticipated delivery date. _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Is this your first pregnancy? If not, how many previous pregnancies have you had?
_____ |

Please note: If your health changes so that you can now answer YES to any of the above questions, tell your fitness or health professional and ask whether you should change your physical activity plan.

I have read, understood and completed this questionnaire.
Any questions I had were answered to my satisfaction.

NAME _____ DATE _____

SIGNATURE _____