

## BICYCLE ERGOMETER TEST PRELIMINARY AND RISK ASSESSMENT FORM

Please fill out the form carefully before the test and return it once arriving at Wellness Center.

### PRELIMINARY INFORMATION

Name:

Date of birth:

Date:

Have the last 24 hours been particularly stressful physically and/or mentally (no/yes, how?)

Have you prepared for the test according to the given instructions? (yes/no)

- Did you avoid alcohol and heavy exercises in the last 24 hours?
- Did you avoid smoking and snus 2 hours before exertion?
- Did you avoid caffeinated beverages 4 hours before exertion?
- Have you had enough sleep the night before the testing?

### RISK ASSESSMENT

The risk assessment form is carried out together with the tester.

To ensure the safety of the test, answer the following questions about **risk factors, symptoms, and diseases** by circling the suitable alternative. Evaluate your **risk classification** before arriving at the test. If you need help filling out the form, you can go through the form with the tester before the test. Risk classification is evaluated with the tester.

#### 1. RISK FACTORS

Have your close relatives (parents, siblings) or your children had coronary thrombosis, heart's coronary arteries procedure, or sudden cardiac death before age 65?

**No**                      **Yes**                      **I don't know**

Do you currently smoke, or have you quit smoking in the last six months?

**No**                      **Yes**                      **I don't know**

Has your systolic blood pressure been >140 mmHg or your diastolic blood pressure > 90 mmHg at least in the last two measurement session Or do you have increased blood pressure caused by medication? **Blood pressure is measured before the test in the test room.**

**No**                      **Yes**                      **I don't know**

Has your total cholesterol or "bad" cholesterol (LDL) been high or "good" cholesterol (HDL) been low, or do you use cholesterol-lowering medication? (If you know lab values, ranges for total cholesterol over 5,2 mmol/l, LDL over 3,4 mmol/l, and HDL under 1,02 mmol/l)

**No**                      **Yes**                      **I don't know**

Has your fasting blood sugar been high the last two times measured? (If you know lab values, over 6,2 mmol/l is considered elevated)

**No**                      **Yes**                      **I don't know**

Is your waistline > 90 cm (women) or 100 cm > (men). *The waistline is measured before the test in the test room.*

**No**                      **Yes**                      **I don't know**

Do you exercise less than three times a maximum of 30 minutes at a time?

**No**                      **Yes**                      **I don't know**

**The number of risk factors according to the answers: \_\_\_\_\_**

## 2. SYMPTOMS

Have you had any of the following symptoms in the last six months?

Chest pain during rest or physical activity, chest pain on the breastbone, shortness of breath, or headache related to physical activity

**No**                      **Yes**                      **I don't know**

Vertigo or cardiac arrhythmia sensations.

**No**                      **Yes**                      **I don't know**

Abnormal exhaustion related to physical activity.

**No**                      **Yes**                      **I don't know**

Musculoskeletal pain that affects movement (for example, back or joint pain)

**No**                      **Yes**                      **I don't know**

**Symptoms according to answers: \_\_\_\_\_**

## 3. DISEASES

Do you have or have you had any of the following illnesses (circle)?

coronary artery disease      myocardial infarction      increased heart disease      stroke

heart valve disease      transient ischaemic attack      cardiac arrhythmia      pacemaker

pain in the calf when walking      cardiomyopathy      deep-vein thrombosis

asthma                                      chronic bronchitis, chronic obstructive pulmonary disease, or pulmonary  
emphysema                                      other blood vessel disease                      other lung diseases                      anemia  
thyroid problems                                      diabetes                      kidney problems                                      liver problems  
osteoarthritis                                      rheumatoid arthritis                                      chronic back disease                                      peptic ulcer  
an operation recently                                      an accident recently                                      low blood potassium or magnesium level  
increased intraocular pressure                                      poor eyesight or hearing  
allergy symptoms related to exertion

Do you have any other diseases or symptoms, or do you take some medicine regularly? Which one?

**No**                                      **Yes**

Have you had a fever or cold that required medication, stomach flu/diarrhea, or other infection causing absence from work in the last three weeks?

**No**                                      **Yes**

Illnesses according to answers: \_\_\_\_\_

## RISK ASSESSMENT RELATED TO TESTING

The risk factors, symptoms and illnesses are evaluated according to the filled preliminary and assessment form. **Based on the previously filled information the customer will be classified into different risk categories.**

### Low-risk

- under 45-year-old men with at most one **risk factor** (section 1) and that are **asymptomatic** (section 2: 1-3)
- under 55-year-old women with at most one **risk factor** (section 1) and that are **asymptomatic** (section 2: 1-3)

### Medium risk

- all 45-year-old and older men and 55-year-old and older women
- everyone with two or more **risk factors** (section 1) and that are **asymptomatic** (section 2: 1-3)

### High-risk

- People with one or more symptoms **referring to heart- or lung disease** (section 2: 1-3) or with **heart- or blood circulation organ** (section 3: 1-12), respiratory **organ** (section 3: 13-15), or **metabolic** (section 3: 16-19) **disease**.

The previously evaluated information and the intended test are defined if the doctor's consultation or presence is required during the test (see chart 1). Particular caution must be taken during the test, which is supposedly maximal for the customer or there is no previous information about customer's capacity.

Recommendation about doctor presence during Fitness test (based on ACSM 2006).			
	Low risk	Medium risk	High risk
Submaximal test (max 85%)	not necessary	not necessary	recommended
Maximal test	not necessary	recommended	recommended

Test will not be performed if, in the last three weeks, you have had a fever or a flu that required medical treatment, or diarrhea/vomiting disease or another infection that required absence from work. Other diseases (section 3: 20-30) and symptoms of locomotor organs (section 2: 4) must also be taken into account when evaluating the safety of the tests.

**CUSTOMERS RISK CLASSIFICATION AND RISK ASSESSMENT (tester confirms)**

**Risk classification:**

**Further information:**

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**Customer's signature and print name**

With signature I prove information to be truthful. I promise that I've read all the questions carefully and answered them according to my best knowledge. I have received answers to my questions about the testing.

**Decision on taking the test:**

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**Tester's signature and print name**

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**Attachment 1. MEASUREMENTS DONE AT WELLNESS CENTER (tester measures at Wellness Center)**

Resting blood pressure:

- Measurement 1:
- measurement 2:

Waistline:

Weight:

Length:

Room temperature:

Date: