

Fort Clinch 100

Spring 2016

Projects: Please look over the following projects and let us know which you would like to participate in; you may do just one or both! We will take every step possible to not interfere with your race experience; none of the testing should interfere with your race times. Our design of these studies is in hope that participants will do all section of the study.

Cardiac measurements: testing time 5 to 10 min.

- Noninvasive cardiac function. We will be performing electrocardiogram (EKG) and blood pressures pre and post-race, to assess alterations to the cardiovascular function of the heart and blood pressure.
- Your blood pressure will be measured at rest and immediately after standing and an EKG will be performed at rest. This will take approximately 5 minutes.
- EKG will only be taken pre and post-race.

Pre-Race Survey

*Information on this survey is private and confidential, and will not be used to diagnose or treat any injuries. This is for research purposes only. Your Race number will be your number associated with this study for data collection and analysis, there will be no direct identifying information associated with presentation of this data in any form.

Competitor Number: _____ Male: ____ Female: ____ Age: _____

Height: _____ Weight: _____ DOB: _____

Email: _____ (If you would like your overall test results sent to you)

Training History: Mark all that apply

<u>Level of Competition</u>	<u>Running surface</u>	<u>Cross training</u>
Recreational only	Treadmill	Biking
Recreational competitive	Street (asphalt)	Swimming
Competitive (HS/College)	Sidewalk	Weights
Elite	Trail	Yoga
Pro	Track	Other
<u>Running data (fill in)</u>	<u>Recent Change in your training</u>	<u>Injury symptoms, occurrence</u>
Years of Running:	Increased mileage	Every step of the run
Average pace/mile:	New Shoes or inserts	Worse toward the end of the run
Average Mileage/week:	Speed work or track work	Worse at the start
Longest single run:	Hill Training	Only after the run ends
Runs per week:	Change in terrain	Next day

Basic Health Questions

Questions	YES	NO
1. Have you ever had or believe you have had a stroke or heart attack?		
2. Have you ever had coronary bypass surgery or any other type of heart surgery?		
3. Do you have any other cardiovascular or lung diseases?		
4. Do you have a history of diabetes, thyroid, kidney or liver disease?		
5. Have you ever been told that you have had an abnormal resting or exercise EKG?		
6. Pain of discomfort in the chest or surrounding areas that occurs when you engage in physical activity		
7. Shortness of Breath		
8. Unexplained dizziness or fainting		
9. Difficulty breathing at night except in upright position		
10. Swelling of the ankles (unrelated to injury)		
11. Heart palpitations		
12. Pain in the legs that causes you to stop walking		
13. Known heart murmur		
14. Are you pregnant or is there a possibility that you could be pregnant		
15. Have you had a surgery or been diagnosed with any disease in the past 3 months?		
16. Have you had high blood cholesterol or abnormal lipids within the last 12 months or are you taking medication to control your lipids?		
17. Do you currently smoke cigarettes or have you quit within the past 6 months?		
18. Has any male in your family had heart disease?		
19. Has any female in your family had heart disease?		
20. Have you ever been diagnosed with high Blood pressure > 140/90		
21. Have you ever had a fasting blood glucose level > 110 mg/dl		
22. Are you currently under any treatment for blood clots		
23. Do you have any problems with your bones, joint or muscles		
24. Do you have any back or neck problems		
25. Have you ever been told by a health care professional that you should not exercise?		
26. Are there any other conditions such as mitral valve prolapse, epilepsy, rheumatic fever, asthma, cancer, anemia, hepatitis, etc.... that may alter your ability to exercise?		
27. During the past six months have you experienced any unexplained weight loss or gain?		

If you have answered yes to any of the previous question 1-27 please explain in the space below.

Are you taking any prescription or nonprescription medications? YES ____ NO ____
if so, please provide name and doses per day in the appropriate tables below.

Prescription

Name	Dose	Frequency	Reason	Use during race

Nonprescription

Name	Dose	Frequency	Reason	Use during race

Have you had an operation within the last year? YES ____ NO ____
if so, please provide type of procedure performed.

Do you have any untreated injuries? YES ____ NO ____ if so, please provide area of body and severity of injuries.

Will you be taking any prescription or nonprescription drugs during this event? (Such as Tylenol, Advil, other pain pills or any other substances) Remember this is total confidential for research only.

What type of footwear will you use for this event (shoes/no shoes, socks/no socks, brand, etc.)?

Shoe Brand	Name/model	Size	Socks/type/brand

Other information about Shoes: (age, modifications, special laces...)

Do you plan to change footwear during this event? YES___ NO___
 if so, please provide the estimated number of footwear changes.

Do you plan to tape any part of your feet? YES___ NO___
 if so, please provide type of tape and placement on each foot.

Current injuries, prior to the race:

Foot/Leg/arm ect.. L/R	Location	Type (blister, cut...)	How long have you had injury

Any other information that you would like to share or you think we might find interesting?_____
