Subject Screening Form

**The Effect of Lateral Bicycle Dynamics on Maximal Power Output**

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|  |  |
| --- | --- |
| Name (please print) : |  |
| Date of Birth: |  |
| Height: |  |
| Weight: |  |
| Shoe size: |  |
| Years of cycling experience: |  |
| Hours of cycling per week: |  |
|  |  |

**PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.**

1. Describe briefly your typical weekly physical exercise. Indicate approximate duration frequency and intensity. For example: *"I ride outside 3 or 4 times per week." or "I ride indoors on a trainer when it is too cold or snowy outside”*.

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1. Are you in good general health?

|  |  |
| --- | --- |
|  Yes  No |  |
| If no, please specify any known problems: |  |
|  |  |

1. Do you have any difficulty with walking, cycling or mobility in general?

|  |  |  |
| --- | --- | --- |
|  Yes  No | |  |
| If yes, please specify: |  | |
|  | |  |

1. Do you have any problem with balance or dizziness?

|  |  |  |
| --- | --- | --- |
|  Yes  No | |  |
| If yes, please specify: |  | |

1. Do you currently have lingering symptoms or pain related to a serious musculoskeletal injury to your legs, feet, or back?

|  |  |  |
| --- | --- | --- |
|  Yes  No | |  |
| If yes, please specify: |  | |
|  | |  |

1. Do you have asthma or exercise-induced asthma?

|  |
| --- |
|  Yes  No |
| If yes, please specifically explain whether your asthma does or does not cause you problems. For example, you could state: *“I usually have trouble breathing when I exercise”* or *“My asthma makes it hard to breathe only when it is cold outside”*, or *“Never had a problem”* or *“Occasionally, I have problems breathing but I have an inhaler that I use”.*: |
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|  |

1. Has a doctor told you that you have high blood pressure?

 Yes  No

1. Have you ever had a heart attack?

 Yes  No

1. Has a doctor told you that your cholesterol is at a high risk-level?

 Yes  No

1. Do you have diabetes or has a doctor told you that you have diabetes or pre-diabetes?

 Yes  No

1. Do you have renal (kidney) disease?

 Yes  No

1. Do you smoke cigarettes?

 Yes  No