**Subject Screening Form**

## Investigating the factors influencing cycling vigor

Investigators: Ross Wilkinson, Ph.D., Robbie Courter, M.S., Shruthi Sukumar, M.S., Alaa Ahmed, Ph.D., Rodger Kram., Ph.D.

Departments of Integrative Physiology & Mechanical Engineering

University of Colorado Boulder

Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Day: \_\_\_\_\_ Month: \_\_\_\_\_\_ Year: \_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_

Years of cycling experience: \_\_\_\_\_\_\_\_\_\_\_\_\_

Hours of cycling per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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”.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of your knowledge:

2. Are you in good general health?

Please circle: yes no

If no, please specify any known problems:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please circle: yes no

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please circle: yes no

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please circle: yes no

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6a. Do you have asthma or exercise-induced asthma?

Please circle: yes no

6b. If yes, please specifically explain that 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.”:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please circle: yes no

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you ever had a heart attack?

Please circle: yes no

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

Please circle: yes no

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

Please circle: yes no

11. Do you have renal (kidney) disease?

Please circle: yes no

12. Do you smoke cigarettes?

Please circle: yes no

13. Do you have any food allergies?

Please circle: yes no

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_