



Name: (print clearly) _____		Date: _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>
DOB: _____	Age: _____	<input type="checkbox"/> Phone: _____	<input type="checkbox"/> E-mail: _____	(Please check preferred)
Physician Name: _____			Phone: _____	
Emergency Contact Name: _____			Phone: _____	

**Do you have a history of any of the following diseases?**

<p>Y N Heart/Vascular problems (please specify)</p> <p>___ heart disease, heart attack, angina</p> <p>___ coronary angioplasty/cardiac surgery</p> <p>___ rapid heartbeats (greater than 100 bpm)/palpitations</p> <p>___ heart murmurs or unusual cardiac findings</p> <p>___ peripheral vascular disease</p> <p>___ stroke</p> <p>___ other _____</p> <p>Y N Metabolic Disease (please specify)</p> <p>___ diabetes</p> <p>___ kidney disease</p> <p>___ thyroid or metabolic disorder</p>	<p>Y N Respiratory problems (please specify)</p> <p>___ asthma _____ chronic bronchitis</p> <p>___ emphysema or COPD _____ other</p> <p>Y N Fainting or dizziness</p> <p>Y N Chest discomfort at rest or during exertion</p> <p>Y N Unusual fatigue or shortness of breath</p> <p>Y N Ankle swelling</p> <p>Y N Major surgery/hospitalization (within last 5 months) (please specify) _____</p> <p>Y N Pregnancy (current or within 2 months postpartum)</p> <p>Y N Neurological disease or condition (such as MS or Parkinson's disease)</p> <p>Other _____</p>
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**For Staff Use: 1**

**Do you presently have any of the following?**

Y N Hypercholesterolemia (total cholesterol greater than 200 mg/dL or HDL less than 35 mg/dL)

Y N Hypertension, blood pressure greater than or equal to 140/90 mm Hg, or on hypertensive medication

Y N Smoking habit (current or quit within last 6 months)

Y N Family history (parents or siblings) of heart disease prior to age 55 (males), 65 (females)

Y N Greater than 20 lbs. overweight (BMI>30)

Y N **WOMEN:** Are you 55 years of age or older?

Y N **MEN:** Are you 45 years of age or older?

Y N Trouble maintaining balance or walking without assistance

Y N Trouble seeing, reading or understanding signs

Y N Require assistance with self-care, daily activities, driving, shopping

Y N Has any doctor restricted your ability to perform exercise and/or other physical activities?

Y N Do you or people close to you have concerns about your ability to remember important things (short-term memory)?

Y N Have you ever had a cancer diagnosis? If so, please specify date and type \_\_\_\_\_

Y N Chronic problems with pain, strength or mobility that restricts use of any of the following body parts: (check all that apply)

\_\_\_ Neck \_\_\_ Back \_\_\_ Shoulder \_\_\_ Hips \_\_\_ Knees \_\_\_ Ankles \_\_\_ Hands \_\_\_ Feet

**For Staff Use: 2**

\_\_\_ How many **days** per week do you get moderate to intense physical activity, such as a brisk walk?

\_\_\_ How many **minutes** per day do you perform activities such as this?

Y N Is this less than 150 minutes of physical activity per week?

**Medication History**

Y N Are you taking any medication for any of the following medical conditions?

\_\_\_ Anxiety/Depression \_\_\_ Stroke \_\_\_ Arthritis \_\_\_ Cholesterol \_\_\_ Thyroid

\_\_\_ High Blood Pressure \_\_\_ Diabetes \_\_\_ Heart \_\_\_ Seizures \_\_\_ Breathing problems

\_\_\_ Other condition that affects exercise (please specify) \_\_\_\_\_

Y N Do any of your medications cause side effects that might affect your ability to exercise (weakness, drowsiness, dizziness, confusion, lack of coordination, muscle or joint pain, etc.)? (please explain) \_\_\_\_\_

- Yes  No I verify I am able to independently gain access to the fitness center, get on and off exercise equipment, utilize the exercise equipment as it was designed, get in and out of the pools, and move freely throughout the showers and locker room facilities.
- Yes  No I verify all information noted above is accurate and I understand it is my responsibility to update the fitness staff about any changes in health status that could affect my ability to safely participate in a fitness program.

Signature (or if under 18, parental guardian signature): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewing Fitness Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff \_\_\_\_\_ PCF required: yes no

Members 13-17 years  Parental Consent signed