

**HEALTH HISTORY PROFILE**

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Name:(print clearly)	Date:	Male	Female
DOB:	Age:	Phone:	E-mail:
Physician Name:		Phone:	
Emergency Contact Name: (print clearly)		Phone:	

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

- | | |
|--|---|
| Y N Heart/Vascular problems (<i>please specify</i>) | Y N Respiratory problems (<i>please specify</i>) |
| ___ heart disease, heart attack, angina | ___ asthma |
| ___ coronary angioplasty/cardiac surgery | ___ chronic bronchitis |
| ___ rapid heartbeats (greater than 100 bpm)/palpitations | ___ emphysema or COPD |
| ___ heart murmurs or unusual cardiac findings | ___ other |
| ___ peripheral vascular disease | Y N Fainting or dizziness |
| ___ stroke | Y N Chest discomfort at rest or during exertion |
| ___ other | Y N Unusual fatigue or shortness of breath |
| Y N Metabolic Disease (<i>please specify</i>) | Y N Ankle swelling |
| ___ diabetes | Y N Major surgery/hospitalization (within last 5 mths.) |
| ___ kidney disease | (<i>please specify</i>) _____ |
| ___ thyroid or metabolic disorder | Y N Pregnancy (current or within 2 months postpartum) |

*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 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
- How many days per week do you get moderate to intense physical activity such as a brisk walk? ___ days
- How many minutes per day do you perform activities such as this? ___ minutes

For Staff Use Only: Less than 90 minutes of physical activity per week Y N*For Staff Use: 2***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*) _____

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. Yes No

Participant/parental Guardian Signature: _____ Date: _____

Reviewing Fitness Professional Signature: _____ Date: _____

Staff _____ PCF required: yes no

Members 13-17 years old Parental Consent signed