HEALTH HISTORY

Form Completion Date _____ / _____ / _____

Name_____ Gender ☐ Male ☐ Female Date of Birth _____ / _____ / _____

Company_____

Suite # _____ Phone (_____) _____ - _____ Social Security No._____ / ___ / _____

Emergency Contact's Name _____ Phone (_____) _____ - _____ Relationship _____

Physician's Name _____ Phone (_____) _____ - _____ Date Last Physical_____ / _____ / _____

Do you have a history of any of the following cardiac, metabolic or pulmonary conditions? (Please check ALL applicable squares)

HEART / VASCULAR (please specify) ☐ Y ☐ N
___ diagnosed high blood pressure (or systolic BP ≥ 140 or diastolic ≥ 90 mmHG on at least 2 separate checks) (12)
___ coronary angioplasty or cardiac surgery (6)
___ heart disease (11), heart attack (10), angina (1),
___ heart murmur (20)
___ peripheral vascular disease (15)
___ stroke (19)
___ other _____ (99)

METABOLIC (please specify) ☐ Y ☐ N
___ diabetes (7)
___ kidney disease (33)
___ thyroid or other metabolic disorders (13)

RESPIRATORY (please specify) ☐ Y ☐ N
___ asthma (26)
___ chronic bronchitis (37)
___ emphysema or chronic obstructive pulmonary disease (29)
___ other _____ (99)

Do you currently have any of the following signs /symptoms/conditions?

Ankle swelling (50) ☐ Y ☐ N
Chest pain (at rest or exertion) (5) ☐ Y ☐ N
Dizziness/fainting (30) ☐ Y ☐ N
Rapid heartbeats or palpitations (31) ☐ Y ☐ N
Shortness of breath (at mild exertion/rest) (18) ☐ Y ☐ N
Unexplained fatigue (unusual fatigue or shortness of breath with usual activities) (36) ☐ Y ☐ N

WOMEN - Are you pregnant? (57) ☐ Y ☐ N

*If you marked **"Y"** to **one or more** of the above, you must obtain your personal physician's consent prior to using the fitness center (see Medical Clearance form on back).*

Do you currently have any of the following coronary risk factors

Female age 55 or above ☐ Y ☐ N
Male age 45 or above ☐ Y ☐ N
Hypercholesterolemia/Elevated cholesterol or abnormal blood lipids (32) (total cholesterol ≥ 200 mg/dL or HDL <35 mg/dL) ☐ Y ☐ N
Smoking habit (within past 6 months) (49) ☐ Y ☐ N
Family history of heart disease (9) (parents or siblings before age 55) ☐ Y ☐ N
Sedentary lifestyle (inactive job, with no regular exercise/fitness program active - 3x/week - or no recreational pursuits) ☐ Y ☐ N

*If you marked **"Y"** to any **two or more** of the items in the box immediately above, you must obtain your personal physician's consent prior to using the fitness center (see Medical Clearance form on back).*

Please check if you have any of the following conditions. These conditions may require medical consultation.

☐ MAJOR SURGERY OR HOSPITALIZATION (within the past 6 months) (45) Please explain _____

☐ ANEMIA (severe <10 GM/dl) (35) ☐ ARTHRITIS (25) ☐ CHRONIC BACK PROBLEMS (28) ☐ ORTHOPEDIC PROBLEMS (joint, bone problems) (46)

Please specify body region if you have arthritis or orthopedic problems_____

What other medical conditions or physical limitations should be considered prior to your participation in an exercise program?

Please specify _____

Please list all drugs (prescription and over-the-counter medications) you are taking:

Drug _____ Reason _____

Drug _____ Reason _____

Drug _____ Reason _____

I VERIFY THAT I HAVE ANSWERED THESE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. IF I HAVE A CHANGE IN MY HEALTH STATUS DURING THE COURSE OF MY EXERCISE PROGRAM, I WILL NOTIFY THE FITNESS STAFF IMMEDIATELY.

Signed:_____ Date _____

FORM REVIEW: (Please initial)

_____Date ____/____/____ Changes ☐ Y ☐ N If **Yes**, describe _____

_____Date ____/____/____ Changes ☐ Y ☐ N If **Yes**, describe _____

_____Date ____/____/____ Changes ☐ Y ☐ N If **Yes**, describe _____

MEDICAL CONSULTATION

Member Name:

Note To Physician

This individual would like to participate in a fitness program offered by Health Fitness Corporation. On the front side of this form the individual has indicated health history information which precludes Health Fitness Corporation from allowing him/her to participate in the fitness program without your consent and recommendations, if any. Please complete the Medical Recommendations section below, and return the form to the individual at your earliest convenience.

Description of Program

If admitted to the fitness program, the individual will be given a series of non-diagnostic tests which may include body flexibility, general muscular strength, body fat percentage, blood pressure and heart rate at rest and in response to submaximal exercise. The fitness test will be performed by a degreed fitness professional. The tests are not conducted in the presence or under the supervision of a physician.

Based on these tests, Health History information (copy on the reverse side), and your recommendations, if any, an exercise program will be developed for the individual to carry out at least three times per week. A typical fitness program may include the following:

- 5 - 10 minute warm-up (light exercise and stretching)
- 10 - 30 minute aerobic activity (running, walking, stairstepping, bicycling, group classes, etc.)
- 10 - 30 minute strength training (resistance machines, free weights, floor exercise)
- 5 - 10 minute cool-down stretching (flexibility activities)

Medical Recommendations

Check one recommendation option below and complete associated questions, if any.

_____ This individual may participate without restriction in all fitness center activities.

_____ This individual may participate in the fitness center program with the following limitations:

_____

_____

Is there a MAXIMUM HEART RATE this individual should not exceed during aerobic exercise?
☐ Yes ☐ No If YES, please specify: _____ beats per minute.

_____ This individual MAY NOT participate in fitness center activities based on the following:

_____

_____

Physician Information

_____ _____ ____/____/____
PRINT Name Signature Date

_____ (____)_____
Full Address Telephone