CELEBRATING 40 YEARS
1979 2019
Wheaton Sport Center
*Your Neighborhood Club*

# HEALTH HISTORY QUESTIONNAIRE

## MEMBER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Birthdate: _____

Cell Phone: _____ Gender: ☐ M ☐ F

Email: _____

## EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Phone: _____ ☐ Home ☐ Cell

## CURRENT PHYSICIAN INFORMATION

Name: _____

Phone: _____ Fax: _____

## PERSONAL HEALTH HISTORY *(Please check any that apply)*

☐ Pregnant ☐ Currently *# Wks:* _____ *# Mos:* _____
☐ Recently *# Wks:* _____ *# Mos:* _____

☐ PERSONAL history of coronary or arterial disease
☐ Heart Attack ☐ Embolism ☐ Stroke ☐ Other
*Explain:* _____

☐ FAMILY history of coronary or arterial disease
☐ Coronary Artery Surgery ☐ Heart Attack ☐ Embolism
☐ Sudden Death ☐ Stroke ☐ Other
*Relationship:* _____ *Age at occurrance:* _____
*Explain:* _____

☐ Hypercholesterolemia *(high cholesterol: ≥200 mg/dl)*
HDL *(if known):* _____ Total *(if known):* _____

☐ Hypertension *(high blood pressure: ≥140/90 mm Hg)*

☐ Impaired Fasting Glucose

☐ Cigarette Smoker *(within the past 6 months)*

☐ Obesity *(Waist girth more than 39 inches)*

☐ Chest pain or tightness at rest or exertion
*Explain:* _____

☐ Unusual cardiac findings
☐ Extra/Skipped Beats ☐ Murmur ☐ MVP
☐ Rapid Heartbeat ☐ Clicks ☐ Other
*Explain:* _____

☐ Pulmonary Condition
☐ Unusual shortness of breath ☐ Asthma ☐ Bronchitis
☐ Emphysema ☐ Other
*Explain:* _____

☐ Orthopedic Problems
☐ Back ☐ Shoulder ☐ Knee ☐ Hip
☐ Foot ☐ Wrist ☐ Ankle
*Explain:* _____

☐ Sedentary Lifestyle
*(Less than 30 minutes or more of exercise on most days of the week)*

☐ Lightheadness ☐ Fainting ☐ Other
*Explain:* _____

☐ Cancer *Type:* _____
*Date Diagnosed:* _____
*Treatment:* _____
*Explain:* _____

☐ Surgeries *Type:* _____ *Date:* _____
*Type:* _____ *Date:* _____
*Type:* _____ *Date:* _____
*Type:* _____ *Date:* _____
*Type:* _____ *Date:* _____

☐ Current Medications *(please list all)*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

☐ Current health/physical limitations which may interfere with exercise

_____
_____
_____
_____

☐ Current Exercise Routine / Regimen
*Activity:* _____ *Time/Session:* _____ *Days/Wk:* _____
*Activity:* _____ *Time/Session:* _____ *Days/Wk:* _____
*Activity:* _____ *Time/Session:* _____ *Days/Wk:* _____
*Activity:* _____ *Time/Session:* _____ *Days/Wk:* _____
*Activity:* _____ *Time/Session:* _____ *Days/Wk:* _____

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# HEALTH HISTORY QUESTIONNAIRE

## WAIVER

I realize that my answers to the Health History Questionnaire will be considered by Wheaton Sport Center Fitness Staff in determining whether I shall be permitted to participate in certain programs offered by Wheaton Sport Center. I also understand that Wheaton Sport Center's decision to permit me to participate in certain programs shall not be interpreted as a determination that would medically safe to do so. I give permission to Wheaton Sport Center Fitness Staff to seek approval regarding any medical concerns, so a safe and appropriate exercise program can be prescribed. However, I understand that Wheaton Sport Center will not contact the physician of every member or prospective member and that it is ultimately my responsibility to consult with my physician to be sure that I have no physical condition that could be adversely affected by any activities at Wheaton Sport Center.

By signing below upon consultation with Wheaton Sport Center Fitness Staff, I certify that the health history information provided is complete and accurate to the best of my knowledge. I agree to inform Wheaton Sport Center Fitness Staff of any changes in my health or medical status. Accordingly, I certify that such answers are true and correct. In the event that any such answer would prove to be untrue, I release Wheaton Sport Center from any and all liability, loss, costs, damage and expense resulting from its reliance herein.

| | |
|---|---|
| *Member Signature* | *Date* |
| *Parent/Guardian Signature (if under 18)* | *Date* |
| *Fitness Staff Signature* | *Date* |

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*FOR OFFICE USE ONLY*

### *FOLLOW UP CALLS / NOTES*

| *DATE* | *NOTE* | *STAFF* |
|---|---|---|
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### *APPROVAL FOR PARTICIPATION*

*Approved By:* _____ *Date:* _____

*Doctor's Release:* ☐ *YES* ☐ *NO* *Date:* _____

*Notes:* _____

### *INDIVIDUALIZED GOALS*