

Stillwater Medical Center
Total Health

Phone: 533-4348 Fax: 624-6596

Fitness Staff Use:	
Needs Physicians Release	Y N
Contacted:	_____
Assessment Scheduled:	_____
Assessment Completed:	_____
Cleared for Exercise:	Y N

Member Information and Health History Primary _____
Cardiologist _____
Other _____

Name _____ Birthdate _____ Gender: M F

Address _____ Phone (1) _____ (2) _____

City, ST _____ e-mail _____

Regular physical activity is fun, healthy and for most people safe. However, some people may have health-related risks that might require them to check with their physician prior to starting an exercise program. To help determine if there is a need for you to see your physician before starting an exercise program, please read the following questions and answer carefully.

All information will be held in the strictest confidentiality. Please mark all TRUE statements.

SECTION 1

You have had:

- _____ Heart Attack/Failure
- _____ Heart Surgery (Bypass, Valve)
- _____ Cardiac Cath/Stent/Angioplasty
- _____ Stroke
- _____ Pacemaker, Implanted Defibrillator, or Rhythm Disturbance
- _____ Heart Valve Disease
- _____ Congenital Heart Disease
- _____ Heart Transplant

Symptoms: (within the past 6 months)

- _____ You experienced chest discomfort with exertion
- _____ You experienced unreasonable breathlessness
- _____ You experienced dizziness, fainting, blackouts
- _____ You take heart medications

-OR-

- _____ You are pregnant (Doctor's Release required)

SECTION 2

- _____ You are a man >45 years of age
- _____ You are a woman >55 years of age, have had a hysterectomy or are postmenopausal
- _____ You currently smoke _____ Have quit smoking within the last 6 months
- _____ You have high Blood Pressure (>140/90) _____ don't know _____ take BP medication
- _____ You have high Cholesterol (>200) _____ don't know _____ take Cholest. Medication
- _____ Have a father or brother who died of heart attack before age 55
- _____ Have a mother or sister who died of heart attack before age 65
- _____ You are Diabetic or take medicine to control your blood sugar
- _____ You are physically inactive (exercise less than one hour/week)
- _____ Your physician has told you that you are more than 20 pounds overweight

SECTION 3:

_____ None of the above is TRUE

- Over Please-

Please answer YES or NO: (If answering YES, please explain.)

YES NO You have recently completed Physical Therapy?
If yes, for what reason? _____ Who provided your therapy? _____

YES NO You have recently completed Cardiac Rehabilitation?
If yes, for what reason? _____

YES NO Are you currently being treated for a bone or joint problem that restricts your
physical activity? _____

YES NO Do you ever lose your balance due to dizziness? _____

YES NO Do you have a history of lung disease? _____
If yes, what kind? _____

YES NO Do you have a thyroid or kidney disease? _____
If yes, what kind? _____

Please list all medications you are taking and their purpose: _____

What services are you more interested in at Total Health? (Indicate all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Fitness Classes | <input type="checkbox"/> Frequent contact from fitness staff |
| <input type="checkbox"/> Aquatic Classes | <input type="checkbox"/> Nutrition advice |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Balance and Fall Prevention |
| <input type="checkbox"/> Event Training (marathon, bike rides) | <input type="checkbox"/> Personal Training Packages |
| <input type="checkbox"/> Build Muscle/Add Body Mass | <input type="checkbox"/> Certain Body Region Focus _____ |
| <input type="checkbox"/> Reduce Body Fat | <input type="checkbox"/> Other (please specify): _____ |

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name

Signature

Date

Emergency Contact: Name _____ Relation _____
Phone _____