hempfield recCenter

Discover. Connect. Belong.

Health History

Please complete both sides of this form and return it prior to your first exercise session.

Last name: _____ First name: _____ M.I. _____

Street address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Primary phone: (_____)_____ Email: _____

Date of birth (mm/dd/yyyy): _____ Gender: Male ☐ Female ☐

Emergency contact: _____ Phone: (_____)_____

Physician name: _____ Phone: (_____)_____

Date of last physical: _____ Findings: _____

Are you currently under a doctor's care? Yes ☐ No ☐ Reason: _____

FAMILY HISTORY - Parents, Grandparents, Siblings

Yes	No		Family Member	Age of Onset
__	__	Heart Disease (circle) Heart Attack, Artery Disease Bypass Surgery, Coronary Surgery	_____	_____
__	__	Sudden Death	_____	_____
__	__	Congenital Heart Disease	_____	_____
__	__	Stroke	_____	_____
__	__	High Blood Pressure	_____	_____
__	__	High Cholesterol	_____	_____
__	__	Obesity	_____	_____

PERSONAL HISTORY

Yes	No	
__	__	Heart Disease: (circle) Heart Attack, Artery Disease, Bypass Surgery, Coronary Surgery
__	__	Congenital Heart Disease
__	__	Heart Murmur
__	__	Chest, Neck, Jaw or Arm Pain/Pressure/Tightness/Heaviness: ___with exertion ___at rest
__	__	Irregular Heart Beat: ___rapid ___slow ___skipped beats ___extra beats
__	__	High Blood Pressure ____/____mm Hg
__	__	Elevated Cholesterol
__	__	Elevated Triglycerides
__	__	Stroke (date ____/____/_____)

PERSONAL HISTORY

Yes	No		Yes	No	
__	__	Smoker (number per day ____)	__	__	Eating Disorder ____Anorexia ____Bulimia
__	__	Cancer	__	__	Pacemaker (date implanted ___/___/_____)
__	__	Diabetes: ___type I ____type II	__	__	Metabolic Disease __Thyroid __Liver __Kidney
__	__	Diagnosed Hypoglycemia	__	__	Arthritis
__	__	Anemia	__	__	Joint Pain, Injury, Replacement Date: ___/___/_____
__	__	Epilepsy or Seizures	__	__	Muscle Pain, Injury
__	__	Osteoporosis	__	__	Back Pain or Injury __upper __middle __lower
__	__	Asthma	__	__	Lightheaded or Fainting
__	__	Anxiety or Depression	__	__	Obesity
__	__	Pregnant (due date ___/___/_____)	__	__	Shortness of Breath at Rest or Mild Exertion
__	__	Unusual Fatigue or Shortness of Breath	__	__	Labored Breathing During Sleep
__	__	Excessive Swelling/Fluid Retention in Ankles	__	__	Pain/Muscle Cramp While Walking

__ __ Are you sedentary or physically inactive?
__ __ Do you exercise on a regular basis? Times per Week _____ Duration _____

Please list physical activities: _____
__ __ Do you take any medications on a regular basis?

Please list medications, dosage and reason: _____

_____

_____

Please list any serious illness, hospitalization or surgical procedures with the past two years: _____

_____

_____

__ __ Drug allergies: Please list _____

_____

NEW MEMBER ORIENTATION

One-on-one (60-90 minutes) orientation includes a body composition analysis along with cardio and circuit equipment instruction. **Children under age 16 must complete orientation to use the facilities.**

____ Yes, I would like to schedule a new member orientation.
Primary Phone: (_____)_____ Email: _____

____ No thanks, I decline the new member orientation.

I attest that the above information is true to the best of my knowledge. By signing this document I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise. I understand and am aware that strength, flexibility, and aerobic exercise including the use of equipment, is a potentially hazardous activity, involving risk of injury and even death. By signing this document, I assume all risk for my health and well being while utilizing the fitness center and hereby waive any claim for bodily injury or property damage against the Hempfield recCenter, its agents, servants and/or employees.

Participant Signature: _____ Date:_____/_____/_____

Parent/Guardian (under 18 years of age) : _____ Date:_____/_____/_____