MEDICAL HEALTH HISTORY QUESTIONNAIRE

Name _____ Date _____

Sex M F Birth date _____ Age _____ Phone # _____

Physician's Name _____

Physician's Phone # _____

Person to contact in Case of Emergency Name _____

Phone # _____ Relationship _____

Are you taking any medications or drug? If yes, list: Name, Reason, Dosage etc.

_____

Are you allergic to any medicines? List. _____

Briefly describe your exercise program now.

_____

Do you now, or have you had in the past:	Yes	No
1. History of heart problems, chest pain or stroke.	____	____
2. Increased blood pressure.	____	____
3. Any chronic illness or condition.	____	____
4. Difficulty with physical exercise.	____	____
5. Advice from physician not to exercise.	____	____
6. Recent surgery (last 12 months).	____	____
7. Pregnancy (now or within last 3 months).	____	____
8. History of breathing or lung problems.	____	____
9. Muscle, joint, or back disorder, or any previous injury still affecting you.	____	____

4. Please indicate any heart, fluid, blood pressure, seizure, diabetic or an other pertinent medications taken on a regular basis, and maximum heart rate not to exceed during exercise where applicable:

_____

Based on the preceding information, please indicate approval of the following exercises and equipment for use by filling in the appropriate boxes below.

_____ may participate in the following activities. Please use a (+) to indicate approval and a (o) to signify contraindicated.

_____ flexibility	_____ exercise bicycles
_____ walking program	_____ aerobics
_____ running /jogging	_____ low-impact
_____ Nordic Track ski simulator	_____ general swimming
_____ calisthenics	_____ lap swimming
_____ water aerobics	_____ free weights
_____ resistance machines	_____ stairmaster
_____ sauna and whirlpool	_____ elliptical cross trainer
_____ rowing machine	_____ Nustep recumbent stepper

Exceptions/ restrictions on above exercises _____

_____

Recommend participation on the fitness program:

Full _____ Limited _____ (Comments, recommendations)

_____

_____

Physicians name (please print) _____

Signature _____ Phone _____

MEDICAL APPROVAL FORM

NAME OF PARTICIPANT: _____ DATE _____

PHONE #: _____

The fitness center at the senior centers in West Hartford provides a number of health/fitness activities, programs and services for the apparently healthy individual. We would appreciate it if you would signify your approval for their participation in this program by completing the following questions.

1. Has the patient experienced any of the following symptoms of CVD?

   _____ Palpitations or abnormal heart rhythms

   _____ Chest pain or pressure (angina type)

   _____ Dizziness or faintness upon exertion

   If so, please explain _____

   _____

2. Does the patient have any of the following CVD risk factors?

   _____ Hypertension

   _____ Hyperglycemia or diabetes mellitus

   _____ Hypercholesterolemia of elevated blood lipids

   _____ Cigarette smoking

   _____ Family history of heart disease

   _____ Obesity

   _____ Sedentary lifestyle

   _____ Tension / stress

3. List any musculoskeletal injuries or problems, such as arthritis, that may be aggravated by exercise or that may limit an exercise program.

   _____

   _____

4. Please indicate any heart, fluid, blood pressure, seizure, diabetic or an other pertinent medications taken on a regular basis, and maximum heart rate not to exceed during exercise where applicable:

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Based on the preceding information, please indicate approval of the following exercises and equipment for use by filling in the appropriate boxes below.

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Exceptions/ restrictions on above exercises _____

_____

Recommend participation on the fitness program:

Full _____ Limited _____ (Comments, recommendations)

_____

_____

Physicians name (please print) _____

Signature _____ Phone _____