Woman's

Health History Questionnaire

We require all program participants to fill out this questionnaire truthfully and completely to help us determine if you are ready to exercise and/or if you require a physician's consent to exercise. This questionnaire is in accordance to the standards of care for fitness facilities advocated by the American Heart Association and the American College of Sports Medicine.

Name (Printed)_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Daytime Phone_____ Date of Birth_____ Email Address_____

Emergency Contact_____ Phone_____

Primary Physician_____ Phone_____

Part One:

If you answer Yes to either #1, #2 or #3 below, we will require a physician's clearance for you to participate in the program. This allows input from your physician.

1. Has your doctor ever told you that you have heart disease (specifically heart attack, heart bypass surgery, leg bypass surgery, congestive heart failure, and/or angina/chest pain?) ☐ Yes ☐ No
2. Has a doctor ever told you that you have diabetes? ☐ Yes ☐ No
3. Are you pregnant or have given birth in the last 2 months? ☐ Yes ☐ No

If you answered YES to any questions in Part One, please read and sign Physician Clearance Process below, then complete side two.

Part Two:

If you answer YES to two or more statements below, we will require one of our fitness staff to review your responses and determine if a physician's clearance is required. If you do not know the answers to some of these questions, the fitness staff will go over this with you.

☐ Yes ☐ No **You are older than 55, or have had a hysterectomy or are postmenopausal.**
☐ Yes ☐ No **You smoke or quit smoking within the past six months.**
☐ Yes ☐ No **Your blood pressure is greater than 140/90 mmHg.**
☐ Yes ☐ No **Your blood cholesterol is greater than 200 mg/dl.**
☐ Yes ☐ No **You have a close blood male relative (father or brother) who had a heart attack or heart surgery before the age of 55 or a close female relative (mother or sister) who had a heart attack or surgery before the age of 65.**
☐ Yes ☐ No **You are physically inactive (you get less than 30 minutes of physical activity at least 3 times per week).**
☐ Yes ☐ No **Your waist circumference is greater than 35 inches.**

Medical Clearance needed? ☐ Yes ☐ No

Fitness Staff Clearance (Signature):_____ **Date:**_____

Physician Clearance Process:

If you are required to have a physician's consent, you can choose one of the following **(circle):**

1. We will fax the form on your behalf and contact you when we receive it.
2. We will provide you with the form to mail or fax to your physician.

Participant approval for clearance_____ Date:_____

Part Three:

Answers to these questions below, may indicate you need a physician's clearance and are eligible for shorter term memberships or programs with increased supervision.

Do you have?

1. Do you have a diagnosed neurological condition? ☐ Yes ☐ No

   Describe:_____

2. Do you use any assistive devices for walking or moving? ☐ Yes ☐ No

   ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other_____

3. Do you have any mental health problems or learning difficulties? *(Alzheimers, Dementia, Depressions, Anxiety Disorder, Phychotic Disorder, Intellectual Disability, Down Syndrome)* ☐ Yes ☐ No

   PLEASE LIST CONDITIONS_____

MEDICAL AND LIFESTYLE HISTORY

Instructions

Complete each question accurately. All information provided is confidential. In most cases, please check mark the correct answers. Only check those that apply.

1. Do you have a history of the following conditions, **medically diagnosed** by a physician or a healthcare professional? *Check all that apply.*

☐ Abnormal EKG or Chest x-ray	☐ Bronchitis, Chronic	☐ Cancer	☐ Hip Problems
☐ Cigarette Smoking	☐ Other Lung Disorders	☐ Hearing Loss	☐ Back Problems
☐ High Blood Pressure	☐ Anemia, blood disorder	☐ Vision Loss	☐ Shoulder Problems
☐ High Cholesterol	☐ Liver Disorder	☐ Mental Illness	☐ Neck Problems
☐ Diabetes	☐ Thyroid Disorder	☐ Osteoporosis	☐ Recent Broken Bones
☐ Peripheral Vascular Disease	☐ Kidney Disorders	☐ Osteopenia	☐ Swollen or Painful Joints
☐ Heart Attack	☐ Hypoglycemia	☐ Urine Leakage	☐ Major Injury
☐ Irregular Heart Beat or Rhythm	☐ Eating Disorders	☐ Chronic Headaches	☐ Balance Problems
☐ Heart Condition	☐ Gout	☐ Phlebitis or Blood Clot	☐ History of Falling
☐ Heart Murmur	☐ Epilepsy or Seizures	☐ Congenital Defect	☐ Joint Replacement
☐ Stroke/TIA	☐ Arthritis	☐ Rheumatic Fever	☐ Spinal Cord Injury
☐ Emphysema	☐ Fibromyalgia	☐ Foot Problems	☐ Other_____
☐ Asthma	☐ Hernia	☐ Knee Problems	_____

2. **Has a doctor given you any activity restrictions?** ☐ No ☐ Yes **If Yes, please describe:**_____

_____

3. ☐ Yes ☐ No Do you currently have an illness or infection?_____

4. ☐ Yes ☐ No Have you been hospitalized or had major surgery within the last year?

5. What operations have you had? Check all that apply and indicate date of operation.

☐ Back _____ ☐ Eyes _____ ☐ Heart_____ ☐ Hysterectomy_____ ☐ Lung _____ ☐ Other_____

☐ Ears_____ ☐ Joint _____ ☐ Hernia_____ ☐ Kidney ____ ☐ Neck _____ _____

6. Have you experienced any of the following symptoms **during exercise or activity** (including walking, climbing, stairs, or working)?

☐ Chest Pain, Heaviness or Tightness ☐ Dizziness or Light-headedness ☐ Please Explain_____
☐ Extreme Breathlessness ☐ Mental Confusion _____
☐ Rapid Heartbeats or Palpitations ☐ Low Back or Neck Pain
☐ Shoulder or Arm Pain/Numbness ☐ Leg Pain or Cramping (claudication) _____

7. Please select any medication or supplements you are currently using:

☐ Diuretics ☐ Nitroglycerin ☐ Herbs or Supplements
☐ Beta Blockers ☐ Cholesterol ☐ NSAIDS / Anti-inflammatory (Motrin®/Advil®)
☐ Vasodilators ☐ Calcium Channel Blockers ☐ Pain Medication
☐ Alpha Blockers ☐ Diabetes / Insulin ☐ Other Drugs_____
☐ Other Cardiovascular Drugs ☐ Chemotherapy/Radiation
☐ Blood Thinners, Aspirin ☐ Antidepressants _____

8. Please list the specific medication names that you are currently taking:_____

_____

_____

9. On average, how many times are you physically active per week?_____

10. How long has it been since you last exercised regularly (2 – 3x per week)?_____

11. On average, how long do you exercise per session?_____

12. On a scale from 1 to 10, how intensely do you exercise?_____

Very Easily 1 2 3 4 5 6 7 8 9 10 *Very Intensely*

13. ☐ Yes ☐ No Do you currently smoke? How long have you smoked?_____

How long has it been since you quit?_____

14. ☐ Yes ☐ No Do you drink caffeinated beverages? How much caffeine do you drink?_____

☐ Yes ☐ No Do you drink alcoholic beverages? How many drinks per week?_____

15. Please rate your daily average stress level.

☐ Low ☐ Moderate ☐ High: I enjoy the challenge
☐ High: sometimes difficult to handle ☐ High: often difficult to handle

16. *Please indicate any other medical conditions or activity restrictions that you may have that are no previously mentioned. It is important that this information be as accurate and complete as possible.*

_____

_____ _____

Agreement and Release of Liability

JM
Initials

In consideration of gaining membership or being allowed to participate in the activities and programs of Woman's Center for Wellness and to use its facilities, and equipment, in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge the Woman's Center for Wellness and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment in the above-mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of the Woman's Center for Wellness or the use of any equipment at the Fitness Center.

_____
Initials

I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and used equipment with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

_____
Initials

I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of the Wellness Center or use of equipment except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/ fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and/or use of equipment without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment in my activities.

Signature _____ **Date**_____

Staff Signature_____ **Date**_____

Staff Witness_____ **Date**_____

Personal Representative's Signature_____ **Date**_____

Relationship to Client_____

Referred to Clinical Staff ☐ Yes ☐ No Date of referral:_____

_____
Initials

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