Wellness Center 55 Plus Health Information

GENERAL INFORMATION
(Please PRINT Legibly)

Date:____

Full Name:

____

Check all that apply: ( ) Bariatric
( ) 55 Plus ( ) SilverSneakers
( ) Volunteer ( ) Thriver/Cancer
( ) Cardiac/Pulmonary Rehab

Date of Birth: ________________________________
( ) Male ( ) Female

Mailing Address:

____
Street

____
City State Zip

Cell or Home#:________________________________

Email:____

Name of Physician:

____

Physician's Phone:

(___)____

MEDICAL HISTORY

Do you have high blood pressure?
- ❑ **NO**
- ❑ **YES, medication?**________________________

Does medication control BP? Yes No

Have you ever had any of the following conditions with your heart? (Check all that apply)
- ❑ **Heart Attack-Date:**______________________
- ❑ **Heart Surgery-Date:**_____________________
- ❑ **Angina-Date:**___________________________
- ❑ **Rapid or irregular heart rate-Date:**__________

NEW MEMBERS:
Please list hospitalizations for surgical operations and/or serious illness __________________________________

____
____
____
____
____

RETURNING MEMBERS:
Have you been hospitalized for any surgical operations or serious illness in the past year?
- ❑ No
- ❑ Yes;
  Explain:_____________________________________
  ____
  ____

List medications or attach list of medications:

____
____
____
____
____
____
____

How did you hear about us? ______________________

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Personal Health History (Please answer all questions. Explain all "YES" answers.)

Have you had?	YES	NO
Asthma		
Arthritis		
Back/Neck problems		
Blood clots		
Chest pain/Discomfort		
Cholesterol problems		
Diabetes		
Difficulty breathing		
Fainting/Dizziness		
Headaches		
Head injury		
Heart murmur		
Heart palpitation		
Irregular heart beat		
Joint problems		
Joint replacements/Implants		
Muscle pain		
Muscle weakness		
Problems with falling		
Pacemaker		
Stroke		

Explain all "YES" answers below:______________________________

Do you suffer from any of the following **during** physical activity?

	YES	NO
Back/neck pain		
Drop in blood pressure		
Falling		
Heart palpitations		
Joint pain		
Pain/discomfort in the chest		
Pain/discomfort in the legs causing you to stop walking		
Shortness of breath		
Unexplained dizziness/fainting		

Family History

Have any of your blood relatives had any of the following problems?

- ❑ Heart disease; you or relative?________________
- ❑ Diabetes; you or relative? ________________
- ❑ Cancer; you or relative? ________________
- ❑ Lung Disease? ________________
- ❑ Arthritis?________________
- ❑ Obesity?________________
- ❑ Stroke?________________
- ❑ High Blood Pressure?________________

NEW MEMBERS ONLY:

Describe any regular physical activity or exercise program that you take part in.

Type of exercise:______________________________

Frequency:______________________________

Duration:______________________________

Intensity:______________________________

Please tell us about your fitness goals:

Are there any other factors or conditions the staff should be aware of before participating in our program?

RETURNING MEMBERS ONLY:

Have you ever referred a new member to us?

- ❑ Yes
- ❑ No

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