Wellness Center

Membership Application

East Jefferson General Hospital
LCMC Health

Last name | First name | Middle initial | Membership #

__/__/__ Date of birth | Male Female Gender: circle one | Married Single Undisclosed Marital Status: circle one

Emergency contact name | ( ) Emergency contact phone number | Height | Weight

Present mailing address | City | State | Zip code

( ) Home phone | ( ) Other phone | Email address

Current employer | Occupation | Phone Email Letter How would you like to be contacted:

Regular physical activity is safe for most people. However, some individuals should check with their physician before they start an exercise program. To help us determine whether you should consult with your physician before starting to exercise with East Jefferson General Hospital Wellness Center, please read the following questions carefully and answer each one honestly. All information will be kept confidential. Please check **yes** or **no**.

Yes	No	
_____	_____	1. Do you have a heart condition?
_____	_____	2. Have you ever experienced a stroke?
_____	_____	3. Do you have epilepsy?
_____	_____	4. Are you pregnant?
_____	_____	5. Do you have diabetes?
_____	_____	6. Do you have emphysema?
_____	_____	7. Do you feel pain in your chest when you engage in physical activity?
_____	_____	8. In the past month, have you had chest pain when you were not doing physical activity?
_____	_____	9. Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?
_____	_____	10. Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?
_____	_____	11. Has a physician ever told you or are you aware that you have high blood pressure?
_____	_____	12. Have you had or do you currently have Cancer? If so, what type_____
_____	_____	13. Has anyone in your immediate family (parents/brothers/sisters) had a heart attack/stroke or cardiovascular disease before age 55?
_____	_____	14. Has a physician ever told you or are you aware that you have a high cholesterol level?
_____	_____	15. Do you currently smoke? If yes, how many per day?_____At what age did you start smoking?
_____	_____	16. Do you have chronic bronchitis or asthma?
_____	_____	17. Are you over the age of 55?
_____	_____	18. Do you have any other medical condition that would limit your participation in an exercise program?
		Specify: _____

Yes to #1-12 or two or more questions: You must have a Physician's Release Form and we highly recommend participating in the Exercise is Medicine Program.

No to all questions: Please schedule a Fitness Assessment and Program Orientation prior to beginning exercising.

Please note: If your health changes so that you then answer YES to any of the above questions, tell your Health Fitness Instructor/Clinical Exercise Physiologist professional at the Wellness Center and ask he/she whether you should change your physical activity program.

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

Member Signature: _____ Date: _____

PR sent on: _____ Date **or** PR declined and is attached. _____ Date MSR Initials: _____