Wellness Center
East Jefferson General Hospital

Health History Questionnaire

_____
Last Name First Name Middle Initial Membership #

_____/_____/_____Male Female_____Married _Single _Undisclosed_____
Date of Birth Gender: Circle one Marital Status: Circle one

_____(_____)_____
Emergency Contact Name Emergency Contact phone number Height Weight

_____,_____
Present Mailing Address City State Zip Code

(___)_____(___)_____
Home Phone Other Phone E-Mail Address

_____Phone Email Letter_____
Current Employer Occupation 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?
____	____	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

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: _____ ***Or*** PR declined and is attached. _____ MSR Initials:_____
Date Date