Appointment Scheduled_____

harward rec center
cometogether

Health History Questionnaire

Last Name_____ First Name_____ Date_____

Primary Phone _____ Birthday_____ Age_____ Gender: M F

1.	Are you a male age 46 or older **OR** a female age 56 or older?	YES	NO
2.	Do you have a family history of Myocardial Infarction (heart attack) or sudden death before 55 years of age in father or brother(s) **OR** before 65 years of age in mother or sisters?	YES	NO
3.	Do you presently smoke cigarettes **OR** have quit within the last 6 months?	YES	NO
4.	Do you have high blood pressure (>140/90) confirmed by 2 separate measurements, **OR** are you taking anti-hypertensive medication?	YES	NO
5.	Do you have high cholesterol (>200 mg) OR low HDL (<35mg) OR are you taking cholesterol lowering medication?	YES	NO
6.	Are you a diabetic?	YES	NO
7.	Do you lead a sedentary lifestyle? (Defined as a combination of sedentary jobs involving sitting for a large part of the day AND no regular exercise or recreational pursuits).	YES	NO
8.	Do you suffer from chest pains?	YES	NO
9.	Do you often feel faint or have spells of severe dizziness?	YES	NO
10.	Do you have respiratory problems, or have you experienced shortness of breath with normal or daily activities? If yes, explain_____	YES	NO
11.	Has a doctor ever told you that you have a bone or joint problem such as arthritis, Back or shoulder pain or have you suffered from a recent orthopedic injury? If yes, explain _____	YES	NO
12.	Are you under the care of a Physical Therapist, Chiropractor or other Medical Professional for a recent injury, accident, or surgery? If yes, explain_____ _____	YES	NO

13. Have you had any major surgeries or illness within the past (6) months? YES NO
If yes, explain_____

14. If you are female, are you **OR** is there a chance you may be pregnant? YES NO

15. Is there any other physical reason that would prevent or hinder your participation in a regular exercise program? If yes explain_____ YES NO

16. Do you perform aerobic/cardiovascular exercise regularly? YES NO
If yes, how often? _____/week
At what intensity level? (circle) High Moderate Low

17. Do you perform strength training exercises regularly? YES NO
If yes, how often? _____/week

18. What are your health and fitness goals?
_____Weight Management _____Maintain/increase cardiovascular endurance
_____Increase Flexibility _____Maintain/increase muscular strength/tone
_____Overall health & well-being _____Train for a specific sport
Other:_____

19. Physician Name_____Phone_____Fax_____
Name Specialty Location

20. Secondary MD/PT_____Phone_____Fax_____
Name Specialty Location

21. Signature_____ Parent's Signature_____
(if under18 years of age)

I give permission for my physician to suggest exercise recommendations to be released to the Harward Recreation Center for the purpose of setting up an exercise program and/or participating in fitness testing.

STAFF USE:

_____No medical clearance needed
_____Medical clearance(s) X _____ HHQ reviewed by_____ Date_____

Membership Type	Expiration or Effective Date
Annual	Exp:
Annual Monthly	Exp: Eff:
No Contract Monthly	Eff:
12-Week Quarterly	Exp:
12-Week Upgrade	Exp:
Punch Pass	Eff:
Scholarship	Eff:
Other	Exp:

Appt #	DATE	TRAINER	APPOINTMENT TYPE/ DURATION
1			
2			
3			
4			
5			
6			
7			
8			

COMMENTS: (3/22)