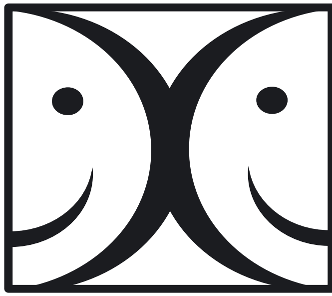
Appt Scheduled____________________________



nampa recreation center

cometogether

Health History Questionnaire

Last Name________________________________ First Name______________________________ Date_________

Primary Phone_________________________ E-mail_____________________________________ Age _______

Birthday__________________ Gender: M F Membership Type: Annual Punch Day Pass Scholarship

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	Question		
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 sister(s)?	YES	NO
3.	Do you presently smoke cigarettes **OR** 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 (<35 mg) **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 the 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 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? If yes, explain____ YES NO

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
_____ Increase flexibility
_____ Overall health & well-being
_____ Maintain/increase cardiovascular endurance
_____ Maintain/increase muscular strength/tone
_____ Train for a specific sport
Other: ____

19. Physician ______________________________ Phone____________ Fax______________
    Name Specialty

20. Secondary MD/PT__________________________ Phone ___________ Fax______________
    Name Specialty

21. Signature_________________________________ Parent's Signature __________________________
    (if under 18 years of age)

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

Staff use:

HHQ Reviewed by________________________________ Date_________________

_____ No medical clearance needed
_____ Medical clearance(s) needed

Appointment	Date	Trainers' initials	Type of Appointment
#1	_______	_____________	_________________
#2	_______	_____________	_________________
#3	_______	_____________	_________________
#4	_______	_____________	_________________

Comments: (11/16)