PIEDMONT FAYETTE HOSPITAL

HEALTH HISTORY QUESTIONNAIRE

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, circle the single best choice for each question. As is customary, all of your responses are completely confidential and may only be used group summaries and/or reports. All information collected as subject to the Privacy Act of 1974. If you have any physical handicaps or limitations, which would require special assistance with this questionnaire, please inform the staff at the Piedmont Fayette Fitness Center.

Name:_____ Occupation:_____

Gender:_____ Age:_____ Birthdate:_____ Ht _____ Wt _____

Address:_____

City:_____ State:_____ Zip:_____Phone:_____

Emergency Contact:_____ Phone:_____

Personal Physician:_____ Phone: _____

1. Have you ever had a definite or suspected heart attack or stroke?……..Yes No
2. Have you ever had coronary bypass surgery or any other type of Heart surgery?……....Yes No
3. Do you have any other cardiovascular or pulmonary (lung) disease (*Other than* asthma, allergies, or mitral valve prolapse)?……..Yes No
4. Have you ever had a history of diabetes, thyroid, kidney, or liver disease? (Please circle which one)……..…….Yes No
5. Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)?……Yes No
6. If you answered YES to any of Questions 1 through 5, please describe:

_____

_____

7. Do you currently have any of the following:
   a. Pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity?…….Yes No
   b. Shortness of breath?……Yes No
   c. Unexplained dizziness or fainting?……..Yes No
   d. Difficulty breathing at night except in upright position?…….Yes No
   e. Swelling of ankles (recurrent and unrelated to injury)?…….. Yes No
   f. Heart palpitations (irregularity or racing of the heart on more than one occasion)?……..Yes No
   g. Pain in the legs that causes you to stop walking (caludication)?…….Yes No
   h. Known heart murmur?…….Yes No
   i. Have you discussed any of the above with your personal physician?..Yes No

   If you have answered YES to any of the above, please describe: _____
   _____
   _____
   _____

8. Within the past 12 months, has a health professional told you that your blood cholesterol or lipids profile was abnormal? …….Yes No

9. Do you currently smoke cigarettes?……. Yes No

10. Have you quit smoking cigarettes in the previous 12 months?…….Yes No

11. Have your father or brother(s) had heart disease prior to age 55 OR Mother or sister(s) had heart disease prior to age 65?……....Yes No

12. Within the past 12 months, has a health professional told you that you Have high blood pressure (systolic $\geq$ 140 OR diastolic $\geq$90)?……Yes No

13. Currently, do you have high blood pressure?…….Yes No

14. Currently, or within the past 12 months, have you taken any Medicines to control your blood pressure?……Yes No

15. Have you ever been told by a health professional that you have a fasting Blood glucose greater than or equal to 140 mg/dl?……..…Yes No

16. If you have answered YES to any of questions 7-15, please describe_____
    _____

17. Are you currently being treated for any other medical condition by a physician?……Yes No

18. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) which may *hinder* your ability to exercise?……...Yes No

19. During the past six months, have you experience any *unexplained* weight loss or gain (greater than ten pounds for no known reason)?…….Yes No

20. Are you currently under any treatment for any blood clots?……..Yes No

21. Do you have problems with bones, joints, or muscles that may be aggravated with exercise?…….Yes No

22. Do you have any back/neck problems?…….Yes No

23. Have you had surgery or been diagnosed with any disease in the past 3 months?……..Yes No
    If yes, please list date_____ and surgery/disease_____

24. Have you been told by a health professional that you should not exercise?…..Yes No

FOR WOMEN ONLY:

25. Are you pregnant or is it likely that you could be pregnant at this time?…Yes No
If yes, what is your expected due date? _____.

26. Do you have a history of miscarriage?…….Yes No

27. Since conception, have you experienced vaginal bleeding?……Yes No

28. Have you had, or do you currently have, Gestational Diabetes?……Yes No

29. If you have answered YES to any of question 25 - 28, please describe:

_____

_____

_____

30. Describe your regular physical activity or exercise program

- Type: _____
- Frequency: _____ days per week
- Duration: _____ minutes
- Intensity: low moderate high (circle one)
- Additional information:

_____

_____

31. Please list below all prescription and over-the-counter medication you are currently taking:

Medicine	Reason for taking:	Dosage:	Amount/Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

32. Are there any medicines that your physician has prescribed in the past 12 months which which you are currently not taking?……Yes No
If so, please list: _____
_____

I have answered the Health History Questionnaire questions accurately and completely. I understand that my medical history is very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions which are known to me, but which I do not disclose to the staff of Piedmont Fayette Fitness Center may result in serious injury to me. If any of the above conditions change, I will immediately inform the staff of Piedmont Fayette Fitness Center of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire. The staff of Piedmont Fayette Fitness Center also verbally explained this statement to me to my to my understanding.

Member Signature: _____ *Date:* _____

PFH Staff Signature: _____ *Date:* _____

For Use by Piedmont Fayette Fitness Center Staff ONLY

Check the identified ACSM major coronary risk factors below

__ Lipids (TCH ≥ 200 or HDL <35)
__ Cigarette Smoking (or quit within the past year)
__ Family History
__ High Blood Pressure/Blood Pressure medications
__ Diabetes/glucose ≥ 140 mg/dl
__ Sedentary
__ Signs or Symptoms of Cardiovascular Disease_____
__ Cardiovascular Disease_____

	Risk Stratification	***Factors***
___	Apparently Healthy	One or No Risk Factors (No medical clearance required)
___	Apparently Healthy Male ≥ 40; Female ≥ 50	One or No Risk Factors (initial medical clearance required)
___	High Risk, No Signs or Symptoms	Two or More Risk Factors (medical clearance required)
___	High Risk, with Signs and Symptoms	One or More Signs/Symptoms With or Without Risks
___	Known Disease	Diagnosed Cardiopulmonary/Metabolic Disease

All clients must give written medical clearance to Piedmont Fayette Fitness Center staff from their personal physician prior to beginning their exercise program.

Revised 8/10/06

Additional Comments:

_____

_____

AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWALS

I (We) hereby authorize Piedmont Fayette Hospital, Inc. Fitness Center, hereinafter called (COMPANY), to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) checking ____ credit card ____ account (select one) indicated below at the depository named below, hereinafter called DEPOSITORY, to debit and/or credit the same to such account for membership fees, additional keycards and towel replacement fees.

Checking Account Information (staff only: _____)

DEPOSITORY NAME_____

BRANCH_____

CITY_____ STATE_____ ZIP _____

TRANSIT/ABA # _____ ACCOUNT # _____

WITHDRAWAL START DATE (MM/DD/YY) _____

Credit Card Information ***(staff only:_____)***

TYPE OF CREDIT CARD _____ EXP DATE _____

CREDIT CARD # _____ SC _____

NAME AS IT APPEARS ON CARD _____

BILLING ADDRESS _____

This authority is to remain in full force and effect until COMPANY has received written notification from me (us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME _____ MEMBER # _____

SIGNATURE _____ DATE _____

COMPANY WITNESS _____ DATE _____

Please attach a voided check if a checking account is selected

ADDENDUM TO PFH FITNESS CENTER
CONTRACT

AUTOMATIC PAYMENT

Upon joining the Piedmont Fayette Hospital Fitness Center, each member will be responsible for membership dues. There will be two options of payment. Dues will either be automatically withdrawn from a checking account or automatically charged to a credit card on the 1st of every month. Members can verify payment withdrawals on his/her own person banking or credit card statements.

AGE POLICY

1. No one under the age of **14** may use the Fitness Center equipment or be on the Fitness Center Floor.
2. Children between the ages of **14-15** yrs are allowed to use the Fitness Center equipment under the supervision of an adult who is **18** yrs or older.
3. Anyone **16** yrs of age or older may use the Fitness Center equipment without supervision at their own risk.
4. You must be at least **18** yrs of age to sign a Fitness Center contract agreement.

KEYCARD POLICY

Every member will be issued <u>one</u> keycard and required to **check in** at the front desk before using the facility. In addition, if a keycard is lost there will be a $5 dollar replacement fee. The replacement fee will be automatically withdrawn from checking account or charged to credit card. Failure to do this could result in termination of membership. If keycard is lost, please notify a staff member to reissue a new one.

It is agreed and understood that all policies apply to all persons receiving membership. I have read and understood the keycard policy and automatic form of payment for membership dues. It is my responsibility to abide by each policy.

_____ _____
Signature Date

ASSUMPTION OF RISK

I, _____, understand that there are certain risks involved with
(Print full name)
exercise here at PFH's Fitness Center. I also understand that it is recommended by this facility that I have a physician's consent and/or have my physician identify any limitations that I may have concerning exercise. By signing this form, I am assuming any and all risks related to my exercise/testing program at PFH's Fitness Center. Those risks include, but are not limited to, muscular/orthopedic injury, joint injury, abnormal blood pressure, fainting, falls, headaches, disorders of the heart, seizures, heart attack, or even death. I knowingly and freely assume full responsibility for my participation here at this facility. The staff, interns, or PFH's Fitness Center will not be held liable for any situations listed above that may happen to me due to my association with the exercise/testing program (before, during, or after).

I do still consent to the administration of any immediate measures deemed advisable by the staff.

I have read and understand the above information and voluntarily accept the known dangers of exercising with or without receiving medical clearance.

_____ _____
Printed Name Date

_____
Signature

_____ _____
Witness (Piedmont Fayette Hospital Fitness Center Staff) Date