☐**Equipment Orientation** ☐**Small Group Training** ☐**Personal Training** ☐**Pilates** ☐**Other**_____

Four Seasons Association Health History Questionnaire

Please complete as thoroughly as possible. We strongly encourage completing the form in the club so staff are available for questions. Depending on your risk factors checked on this questionnaire, guidelines from the American Heart Association and the American College of Sports Medicine may recommend physician clearance prior to exercise.

If a physicians clearance is required, Four Seasons will contact your health care provider before prescribing an individualized exercise program. **Please feel free to use the facility on your own.**

Personal Information

Name: _____ *Today's Date:* _____/_____/_____

Membership #: _____-_____-_____

*Date of Birth:*_____/_____/_____ *Age:* _____

*Day Phone:*_____ *Evening Phone:* _____

Physician Information

Physician: _____

Office: _____ *Fax Number:* _____

Section 1

Please check all that apply to you.

- ☐ Heart attack
- ☐ Heart surgery
- ☐ Cardiac Catheterization
- ☐ Coronary Angioplasty
- ☐ Pacemaker/Implantable Defibrillator
- ☐ Heart Valve Disease
- ☐ Heart Transplantation
- ☐ Congenital Heart Disease
- ☐ Chest Discomfort with exertion
- ☐ Experience unreasonable breathlessness
- ☐ Experience dizziness, fainting, blackouts
- ☐ Take heart medications
- ☐ Currently pregnant
- ☐ Musculoskeletal problems
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ **NOTHING IN SECTION 1 APPLIES**

Section 2

Please check all that apply to you.

- ☐ Male older than 45 years
- ☐ Female older than 55 years or had a hysterectomy or postmenopausal
- ☐ Current smoker
- ☐ Blood pressure greater than 140/90
- ☐ Don't know your blood pressure
- ☐ Currently on blood pressure medication
- ☐ Currently inactive (less than 30 Minutes at least 3 days/week)
- ☐ Cholesterol greater than 240 mg/dL
- ☐ Don't know your total cholesterol
- ☐ Your brother/father had a heart attack or stroke before age 55 and/or sister/mother had a heart attack before age 65
- ☐ Diagnosed with diabetes or take medicine to control your blood sugar
- ☐ Currently 20 pounds overweight
- ☐ **NOTHING IN SECTION 2 APPLIES**

☐**Equipment Orientation** ☐**Small Group Training** ☐**Personal Training** ☐**Pilates** ☐**Other**_____

Section 3

Please check all that apply to you.

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Carpel Tunnel
- ☐ Cerebral Palsy
- ☐ Chronic Fatigue Syndrome
- ☐ Clotting Disorder
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Headaches/Migraines
- ☐ Heartburn
- ☐ Hepatitis
- ☐ HIV/Acquired Immune Deficiency Syndrome
- ☐ Irritable Bowel
- ☐ Joint Problems
- ☐ Kidney Stones
- ☐ Lymphedema
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Pulmonary Hypertension
- ☐ Rheumatoid Arthritis
- ☐ Sinusitis
- ☐ Systemic Lupus Erythematous
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ Other: _____

Section 4

Please check all that apply to your personal goals:

- ☐ Lose Weight, # of pounds_____
- ☐ Gain Weight, # of pounds_____
- ☐ Improve Flexibility
- ☐ Increase Tone of Muscles
- ☐ Increase Strength/Power
- ☐ Increase Muscular Size
- ☐ Improve Cardiovascular Ability
- ☐ Train for an event, _____
- ☐ Improve BP, Cholesterol, and/or Blood Glucose Levels
- ☐ Physician Recommended
- ☐ Improve Overall Health
- ☐ Decrease Stress
- ☐ Feel Better / Improve Energy
- ☐ Other: _____

Section 5

Please list all prescribed or over the counter medications, herbs or supplements that you are currently taking including dosage and frequency.

_____

_____

_____

_____

_____

_____

Section 6

Current Height_____feet ____ inches

Current Weight _____pounds

***Record numbers below if known**:*

Blood Pressure_____/_____

Resting Heart Rate_____

Total Cholesterol_____

Staff Notes:

_____

_____

_____

_____

Date Received: _____ / _____ / _____

Received by (staff): _____

Scanned into member account? ___Y ___N

Dave Received Physician Clearance: __/__/__