Carolina Regional Heart Center
THE FITNESS CENTER

Initial: _____ Card: _____
Orientation: _____

Health Questionnaire

Name: _____ Birth date: _____

Gender: M / F Height: _____ Weight: _____ Age: _____

Emergency Contact: _____ Contact Phone #: _____

Primary MD: _____ Cardiologist: _____ Other MD: _____

Regular physical activity is safe for most people. However, some individuals should check with their physician before they start an exercise program. To determine if you should consult with your physician before beginning an exercise program at The Fitness Center, please read the following questions carefully. All information will be kept confidential.
Please check YES or NO.

YES	NO		
☐	☐	1.	Have you had a diagnosed heart attack or suspected heart attack or stroke? Explain: _____
☐	☐	2.	Have you had bypass surgery or any other type of heart surgery? (Example: pacemaker, ICD, valve repair/replacement) _____
☐	☐	3.	Have you been diagnosed with any cardiovascular or pulmonary disease? (Example: COPD, CHF, Chronic bronchitis, or asthma) _____
☐	☐	4.	Have you ever been diagnosed with diabetes (Type I or II), thyroid, kidney or liver disease?
☐	☐	5.	Do you feel discomfort in your chest when you engage in any activity and/or at rest?
☐	☐	6.	Do you experience discomfort in breathing during exertion and/or at rest?
☐	☐	7.	Do you ever lose consciousness or lose your balance due to chronic dizziness?
☐	☐	8.	Do you take heart medications?
☐	☐	9.	Do you have an orthopedic problem (back/joint)? Describe: _____
☐	☐	10.	Have you had surgery in the last year? Describe: _____
☐	☐	11.	Has anyone in your immediate family (parents/brother/sister) had a heart attack, stroke, or cardiovascular disease before the age of 55?
☐	☐	12.	Has a physician ever told you that you have high cholesterol?
☐	☐	13.	Has a physician ever told you that you have high blood pressure?
☐	☐	14.	Do you currently smoke?
☐	☐	15.	Do you experience skipped heart beats or a rapid resting heart rate?
☐	☐	16.	Have you ever been diagnosed with peripheral vascular disease?
☐	☐	17.	Do you experience any ankle swelling?
☐	☐	18.	Do you experience leg pain upon exertion?
☐	☐	19.	Have you ever been told you have a heart murmur?

Other health related concerns: (examples: cancer, epilepsy, multiple sclerosis, etc.)

_____

_____

_____

601 N. Elm St. P.O. Box HP-5 High Point, NC 27261 Phone # 336-878-6221 Fax # 336-878-6026

Carolina Regional Heart Center
THE FITNESS CENTER

Please list all medications below including dosage:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Known drug allergies: _____

I have read, understood, and completed this questionnaire to the best of my knowledge. I understand that misinformation or false statements may result in revocation of this application or membership resulting there from. I understand checking YES to any question on this Health Questionnaire may require a physician's clearance. If any of the above conditions change, I will immediately inform The Fitness Center staff. I knowingly and willingly, assume all risk of injury resulting from my failure to disclose accurate, complete and up to date information in accordance with the above questionnaire. Any questions that I had were answered to my full satisfaction.

Signature: _____ Date: _____

For Physician Only

The Fitness Center at High Point Regional Health System is at the forefront of preventative medicine. Our MEDEX (MEDically supervised EXercise) program is designed for individuals who need better management of their risk factors associated with disease. Please review the medical history information provided on this page and place a check next to the program that you feel is appropriate for this individual.

☐ General Membership - No restrictions, age related heart rate zone utilized

☐ MEDEX Membership - Exercise restrictions as related to health history.

- ☐ Level 1 - This includes individuals with any significant health issues or multiple risk factors. Restricted hours of usage are enforced due to availability of a greater staff skill set and ratio.
- ☐ Level 2 - This includes individuals who have stable or managed disease and/or risk factors. No restrictions on usage of facility.

Comments, limitations, or recommended heart rate range:

_____

_____

_____

☐ I do not recommend exercise for this individual at this time.

Physician Signature: _____ Date: _____

601 N. Elm St. P.O. Box HP-5 High Point, NC 27261 Phone # 336-878-6221 Fax # 336-878-6026