Atrium Health
Wake Forest Baptist

High Point Medical Center
The Fitness Center

Pre-Participation Questionnaire

Name: _____ **Date of Birth**: _____/_____/_____ **Gender**: _____

When you use The Fitness Center facilities and its exercise equipment, or participate in a fitness program, you do so at your own risk. We encourage you to speak to your healthcare provider before becoming a member of or participating in any fitness program at The Fitness Center, specifically based on your answers below.

Please circle best answer:

1. Do you currently participate in physical exercise on a regular basis (minimum 30 minutes per day, 3 days a week)? **YES or NO**
2. Are you currently being treated by your healthcare provider for any known disease(s) such as cardiac, renal, metabolic, lung or cancer? **YES or NO**
3. Do you currently experience any of the following symptoms? **YES or NO**
    a. Uncontrolled blood pressure
    b. Dizziness or loss of balance
    c. Irregular heartbeat
    d. Fluid retention
    e. Uncontrolled blood sugar
    f. Chest pain
    g. Shortness of breath
    h. Increased fatigue
4. Do you have an orthopedic concern that hinders exercise? **YES or NO**
5. Has any healthcare provider told you **NOT** to participate in regular physical exercise within the last twelve months? **YES or NO**
6. Do you know of any other reason **NOT** to participate in physical exercise? **YES or NO**

If you want to disclose any pertinent information, please do so below:

_____

_____

_____

I have read, understood, and completed this questionnaire to the best of my knowledge. 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 questionnaire.

Signature: _____ **Date**: _____/_____/_____

601 N. Elm St. P.O. Box HP-5 High Point, NC 27261 Phone# (336) 878-6221 Fax# (336) 878-6252

Revised: 12/2025