MRN:_____ Membership Type: _____

Wellness Gym Member Information

Name:_____
Address: _____
City:_____State:_____Zip Code: _____
Phone:(H)_____ (C)_____
Email: _____

Date of Birth:_____Age:_____ SDCA Patient? Yes No
Emergency Contact:_____ Phone: _____
Cardiologist:_____ PCP:_____
Last Office Visit:_____ Gym Orientation Date: _____

Cardiac Medical History: Ifyou have had any of the following, please explain. Include Date of Diagnosis and/or Intervention.

Heart Attack _____
Stents _____
Angina _____
Heart Rhythm Abnormalities _____
Heart Valve Disease _____
Congestive Heart Failure _____
Heart Surgery _____

Cardiac Risk Factors:

Have you ever smoked? YES / NO Packs Per Day _____ Years Smoking _____
Do your Currently Smoke? YES / NO What year did you quit smoking? _____
Are you diabetic or pre-diabetic? YES / NO If yes, which type? PRE / TYPE 1 / TYPE 2
Have you been diagnosed with high cholesterol? YES / NO
Have you been diagnosed with high blood pressure (hypertension)? YES / NO
Please list parents, children, grandparents, siblings with thefollowing illnesses:
Heart Disease, stroke, diabetes, high blood pressure

_____

_____

What is your current height? _____ Weight? _____ Waist Size? _____

Physical Activity: In the last 3 months, how frequently have you participated in physical activity sessions lasting 30-minutes or longer? (This includes fitness classes, hikes, brisk walks, and/or bike rides.)

Types of activities? _____

Days per week? _____ Level of Intensity? Low / Moderate / Vigorous

Previous Medical History:

If you have had any of the following, please explain. Include Date of Diagnosis and/or Intervention.

Cancer (Include type and treatments) _____

_____

Neurological Disorders (Including Neuropathy/Stroke/TIA/Parkinson's) _____

_____

Pulmonary Disorders _____

_____

Orthopedic Injuries and/or Surgeries (Including arthritis/osteoporosis) _____

_____

Spinal Injuries and/or Surgeries _____

_____

Any other significant illnesses or surgeries _____

_____

_____

Do you currently experience any of the following symptoms?

Chest discomfort with exertion? ◯ YES / NO ◯

Unreasonable breathlessness? ◯ YES / NO ◯

Dizziness, fainting, or blackouts? ◯ YES / NO ◯

Ankle swelling? ◯ YES / NO ◯

An unpleasant awareness of a forceful, rapid, or irregular heart rate? ◯ YES / NO ◯

A burning or cramping sensation in your lower legs when walking short distances ◯ YES / NO ◯

Has a physician ever told you that you should not exercise? ◯ YES / NO ◯
If yes, please explain.

____

____

____

MEDICATION ALLERGIES:

____

____

____

____

MEDICATIONS (Please include over the counter medications and herbal supplements.)

Medication	Dosage and Frequency	Reason for Taking