Hillcrest Fitness Center
Membership Health Information

TODAY'S DATE:____________________

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date	Social Security #

Address	City	State	Zip	Home Phone	Business Phone

Occupation	Company Name	Sex	Age	Marital Status
		M F		S M D W

Person to Notify in Case of Emergency______________________________________Relationship____________________________________

Address____Phone Number__________________________________

Date of Last Physical Examination_______________________Doctor____

Personal Physicain_________________________________Address____

FAMILY HISTORY			IF LIVING		IF DECEASED	
	Sex		Age	Health	Age of Death	Cause
Father						
Mother						
Brothers/Sisters*(*Circle Sex*)						
	M	**F**				
	M	**F**				
	M	**F**				
	M	**F**				
	M	**F**				
Husband/Wife						
Sons/Daughters* (*Circle Sex*)						
	M	**F**				
	M	**F**				
	M	**F**				
	M	**F**				
	M	**F**				

Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke ________ Heart Attack ________ Diabetes ________ High Blood Pressure ________

Personal Habits: (Circle)

Yes No Do you regularly smoke? Cigarettes ____ For how long? _____ How many packs/day? ____ Pipe ___ Oral tobacco____

Yes No Do you used to smoke but quit? How long ago did you quit? _______ Years you smoked? _____ Packs/day? _______

Yes No Do you regularly drink alcohol? 1 oz. per day ____ 2 oz. per day ____ 4 oz. per day ____ over 6 oz. per day _____

BEER: 1 bottle per day _____ 2 bottles per day _____ over 4 bottles per day _____

LIST ALL MEDICINES YOU PRESENTLY TAKE:

MEDICINE	DOSE	TIMES EACH DAY	REASON TAKEN

ARE YOU ALLERGIC TO ANY MEDICINES ____Yes____No IF SO, PLEASE LIST:

1.________________________________ 2. ________________________________ 3. ________________________________

LIST ALL OPERATIONS OR HOSPITAL ADMISSIONS YOU HAVE HAD:

TYPE OF OPERATION	HOSPITAL	DATE	NAME OF DOCTOR

LIST ALL SERIOUS ILLNESSES NOT REQUIRING HOSPITAL ADMISSION:

ILLNESSES	WHERE	DATE

Have you ever had shortness of breath? (Circle)

Yes No Doing your usual work?
Yes No Climbing a flight of stairs?
Yes No Which awakens you at night?

Have you ever had: (Circle)

Yes No Rheumatic fever?
Yea No Chronic bronchitis or emphysema?
Yes No Abnormal chest X-ray?
Yes No Palpitation or pounding heart?
Yes No Heart attack or coronary artery disease?
Yes No High blood pressure?
Yes No Breathing difficulty, including asthma?
Yes No Tuberculosis or positive TB skin Test?
Yes No Irregular or fast heart beat?
Yes No Any heart problem?
Yes No Abnormal electrocardiogram?
Yes No Diabetes or sugar in urine?

Have you ever had chest pain or tigfhtness in the chest which begins when: (Circle)

Yes No When exerting yourself?
Yes No When walking against a wind?
Yes No When walking up a hill?
Yes No When walking fast?
Yes No After a heavy meal?
Yes No Radiates down the arm?
Yes No Disappears if you rest?
Yes No Occurs only at rest?
Yes No When walking in cold weather?
Yes No When upset or excited?

Have you ever had: (Circle)

Yes	No	Pains in calves of legs when walking?	Yes	No	Neck injury, including whiplash?
Yes	No	Foot trouble?	Yes	No	Phlebitis or inflamed leg veins?
Yes	No	Back trouble including lumbar strain?	Yes	No	Sciatica?
Yes	No	"Trick" or locking knee?	Yes	No	Pain in the big toe?
Yes	No	Bone or joint deformity?	Yes	No	Fracture or broken bone?
Yes	No	Arthritis or bursitis?	Yes	No	Disc disease or ruptured disc?
Yes	No	Paralysis?	Yes	No	Amputation?

Please briefly describe your current exercise program: ____________________

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Please list the goals you hope to achieve from your exercise program: ____________________

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Please list your e-mail address if you would like to receive periodic information about the Fitness Center:

____________________ **@** ____________________ ▪ ________