

HILLCREST FITNESS CENTER

Membership Health Information

DATE: _____

PERSONAL INFORMATION

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		Gender M F	Age	Marital Status S M D W

Person to Notify in Case of Emergency _____ Relationship _____

Address _____ Phone Number _____

Date of Last Physical Examination _____ Doctor _____

Personal Physician _____ Address _____

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

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

Do you know of any blood relative that 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 Did 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:

TYPE OF OPERATION/ADMIT	HOSPITAL	DATE	NAME OF DOCTOR

LIST ALL SERIOUS ILLNESSES NOT REQUIRING HOSPITAL ADMISSION:

HOSPITAL	REASON	DATE	NAME OF DOCTOR

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

Have you ever had chest pain or tightness in the chest that begins when: (Circle)

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

Have you ever had: (Circle)

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

Please briefly describe your current exercise program:

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

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

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