HEALTH HISTORY FORM

Elsie Stuhr Center

5550 SW Hall Blvd, Beaverton, OR 97005
Phone (503) 629-6342 | Fax: (503) 629-6347

For Office Use Only

ACCOUNT	DISTRICT STATUS
❑ Yes	❑ In-District
❑ New	❑ Out of District

MEMBERSHIP	ORIENTATION
❑ S&F	❑ Beginning
❑ SS	❑ Next Step
❑ Neither	❑ Pers/Partner
	❑ Silver Programs
	❑ Personal Training

NOTES: _____

_____

Staff: _____ Date: _____/_____

**You must have a current THPRD residency card to sign up for programs.*

Please print clearly

Name		*Age*
Address		*City/St/Zip*
THPRD Card#	❑ *In-District* ❑ *Out-of-District*	*Phone*
Emergency Contact	*Relationship*	*Emergency Contact Phone*

Are you currently on an exercise program? ❑ NO ❑ YES Type of exercise _____

Frequency: _____ days per week Duration: _____ minutes Intensity: ❑ Low ❑ Moderate ❑ High

Please check all that apply:

Currently	In the Past	I have a… / I've had a...
❑	❑	fitness room/gym membership
❑	❑	strength training program
❑	❑	cardiovascular fitness program

❑ I want both a cardiovascular fitness and strength training program
❑ I want a cardiovascular fitness program only
❑ I want a strength training program only

Areas of Interest
❑ Strength Training Machines
❑ Free Weights
❑ Treadmill
❑ Recumbent Bike
❑ Nu-step
❑ Elliptical Cross Trainer
❑ Seated Elliptical Trainer
❑ All Motion Trainer (AMT)
❑ Other: _____

_____

Fitness Goals _____

_____

_____

I have answered the health history questionnaire accurately and completely. I understand that my medical history is a very important factor in the development of my fitness program. If any of the above conditions change, I will immediately inform the fitness room supervisor of those changes.

Signature _____ Date _____

Medical Provider (Hospital/Clinic) _____

Personal Physician _____ Physician Phone _____

Please check all that apply	Condition applies to me	I take medication for this condition
Heart attack or stroke	❑	❑
Coronary bypass surgery or other heart surgery	❑	❑
High blood pressure	❑	❑
Blood clots	❑	❑
Diabetes	❑	❑
Gastrointestinal disease	❑	❑
Unexplained weight loss/gain	❑	❑
Cancer	❑	❑
Depression or other psychological condition	❑	❑
Neuromuscular disease	❑	❑

	Condition applies to me	I take medication for this condition
Pacemaker	❑	❑
Abnormal resting or exercise EKG	❑	❑
Gallbladder disease	❑	❑
Kidney/liver disease	❑	❑
Back/neck problems	❑	❑
Arthritis	❑	❑
Osteopenia *(*see box below)*	❑	❑
Osteoporosis *(*see box below)*	❑	❑
Bone, joint or muscle pain aggravated by exercise	❑	❑
Chronic pain	❑	❑

Date of last bone density scan _____ T-score on bone density scan (if available)? _____

Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, anemia, hepatitis, specific cancer, etc.) that may hinder your ability to exercise? ❑ No; ❑ Yes. If yes, please explain:

_____

_____

Please list below all prescription and over-the-counter medications you are currently taking:

Medicine	Reason for Taking	Dosage	Frequency

Are there any medications that your physician has prescribed to you in the past 12 months that you are currently not taking? ❑ NO ❑ YES, If yes, please explain: _____

_____

Family History (check all that apply):
❑ Family history of heart disease before age 55
❑ Family history of diabetes
❑ Family history of hypertension (high blood pressure)
❑ Family history of stroke
❑ Family history of obesity

Do you currently smoke cigarettes or have quit within the past 6 months? ❑ NO ❑ YES

Have you ever been told by a health professional that you should not exercise? ❑ NO ❑ YES, If yes, please explain:

_____

_____

Have you ever been given restrictions or contraindications by a health professional concerning your exercise program or activity level? ❑ NO ❑ YES, If yes, please explain:

_____

_____

Do you have any of the following (check all that apply):
❑ Pain or discomfort in the chest or surrounding area that occurs at rest or during physical activity
❑ Shortness of breath at rest or during physical activity
❑ Unexplained dizziness or fainting
❑ Difficulty breathing at night except in upright position
❑ Swelling of the legs/ankles (recurrent and unrelated to injury)
❑ Heart palpitations (rapid or irregular heart rate)
❑ Pain in the legs that causes you to stop walking (claudication)
❑ Known heart murmur
❑ Joint replacement(s) list:_____

In the past year, have you had a significant change in weight? ❑ NO ❑ YES, weight difference? (+/-) _____

Have you discussed any of the above with your physician? ❑ NO ❑ YES, If yes, please explain:

_____

_____

Have you had surgery or been diagnosed with a disease in the past year? ❑ NO ❑ YES, If yes, please explain:

_____

Have you been hospitalized in the past year? ❑ NO ❑ YES, If yes, please explain:

_____

_____

for helping us with the tools to provide you with a better personal work out program.