TriHealth
Fitness & Health Pavilion

HEALTH HISTORY PROFILE

6200 Pfeiffer Road • Cincinnati, OH 45242
www.TriHealth.com

Consult Scheduled
Date: _____
Time: _____

AWARD WINNER
MEDICALFITNESS Association

Name: (print clearly) Date: Male Female

DOB: Age: ☐ Phone: ☐ E-mail: (Please check preferred)

Physician Name: Phone:

Emergency Contact Name: Phone:

Do you have a history of any of the following diseases?

Y N Heart/Vascular problems (please specify)
- ___ heart disease, heart attack, angina
- ___ coronary angioplasty/cardiac surgery
- ___ rapid heartbeats (greater than 100 bpm)/palpitations
- ___ heart murmurs or unusual cardiac findings
- ___ peripheral vascular disease
- ___ stroke
- ___ other

Y N Metabolic Disease (please specify)
- ___ diabetes
- ___ kidney disease
- ___ thyroid or metabolic disorder

Y N Respiratory problems (please specify)
- ___ asthma ___ chronic bronchitis
- ___ emphysema or COPD ___ other

Y N Fainting or dizziness
Y N Chest discomfort at rest or during exertion
Y N Unusual fatigue or shortness of breath
Y N Ankle swelling
Y N Major surgery/hospitalization (within last 5 months) (please specify) _____
Y N Pregnancy (current or within 2 months postpartum)
Y N Neurological disease or condition (such as MS or Parkinson's disease)
Other _____

For Staff Use: 1

Do you presently have any of the following?

Y N Hypercholesterolemia (total cholesterol greater than 200 mg/dL or HDL less than 35 mg/dL)
Y N Hypertension, blood pressure greater than or equal to 140/90 mm Hg, or on hypertensive medication
Y N Smoking habit (current or quit within last 6 months)
Y N Family history (parents or siblings) of heart disease prior to age 55 (males), 65 (females)
Y N Greater than 20 lbs. overweight (BMI>30)
Y N **WOMEN:** Are you 55 years of age or older?
Y N **MEN:** Are you 45 years of age or older?
Y N Trouble maintaining balance or walking without assistance
Y N Trouble seeing, reading or understanding signs
Y N Require assistance with self-care, daily activities, driving, shopping
Y N Has any doctor restricted your ability to perform exercise and/or other physical activities?
Y N Do you or people close to you have concerns about your ability to remember important things (short-term memory)?
Y N Have you ever had a cancer diagnosis? If so, please specify date and type _____
Y N Chronic problems with pain, strength or mobility that restricts use of any of the following body parts: (check all that apply)
___ Neck ___ Back ___ Shoulder ___ Hips ___ Knees ___ Ankles ___ Hands ___ Feet

For Staff Use: 2

_____ How many **days** per week do you get moderate to intense physical activity, such as a brisk walk?
_____ How many **minutes** per day do you perform activities such as this?
Y N Is this less than 150 minutes of physical activity per week?

Medication History

Y N Are you taking any medication for any of the following medical conditions?
___ Anxiety/Depression ___ Stroke ___ Arthritis ___ Cholesterol ___ Thyroid
___ High Blood Pressure ___ Diabetes ___ Heart ___ Seizures ___ Breathing problems
___ Other condition that affects exercise (please specify) _____

Y N Do any of your medications cause side effects that might affect your ability to exercise (weakness, drowsiness, dizziness, confusion, lack of coordination, muscle or joint pain, etc.)? (please explain) _____

☐ **Yes** ☐ **No** **I verify I am able to independently gain access to the fitness center, get on and off exercise equipment, utilize the exercise equipment as it was designed, get in and out of the pools, and move freely throughout the showers and locker room facilities.**

☐ **Yes** ☐ **No** **I verify all information noted above is accurate and I understand it is my responsibility to update the fitness staff about any changes in health status that could affect my ability to safely participate in a fitness program.**

Signature (or if under 18, parental guardian signature): _____ **Date:** _____

Reviewing Fitness Professional Signature: _____ **Date:** _____

Staff _____ **PCF required: yes no** **Members 13-17 years** ☐ **Parental Consent signed**