**PERSONAL INFORMATION RECORD**

**CLINICAL INFORMATION**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
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<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>AGE</th>
<th>PHONE 1</th>
<th>HOME</th>
<th>CELL</th>
<th>WORK</th>
<th>PHONE 2</th>
<th>HOME</th>
<th>CELL</th>
<th>WORK</th>
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**EXERCISE HISTORY**

Do you currently exercise regularly? □ No □ Yes, specify type of activity: ______________________________

How often ___________________________ Duration of exercise session __________________

**MEDICAL HISTORY**

- Has your doctor ever said you have a heart condition or that you should participate in physical activity only as recommended by a doctor? □ Yes □ No
- Do you feel pain in your chest during physical activity? □ Yes □ No
- In the past month, have you had chest pain when you were not doing physical activity? □ Yes □ No
- Is your doctor currently prescribing drugs for your blood pressure or a heart condition? □ Yes □ No
- Do you lose your balance from dizziness? □ Yes □ No
  Do you ever lose consciousness? □ Yes □ No
- Are you diabetic? □ Type I □ Type II □ Yes □ No
- Have you ever had a stroke? □ Yes □ No
- Do you have a bone or joint problem that could be made worse by a change in your physical activity? □ Yes □ No
- Do you know of any condition or reason you should not participate in physical activity? □ Yes □ No
  Please Comment ______________________________

- Are you pregnant? (Physician’s release and recommendation required) □ Yes □ No
- Are you 65 or over? (Physician’s release and recommendation required) □ Yes □ No
# PERSONAL INFORMATION RECORD

## LIFESTYLE

- **Have you ever used tobacco products?**
  - Yes
  - No
  - How long?_________________________
  - Frequency?_____________________
  - Quit Date:

- **Do you consume alcohol?**
  - Yes
  - No
  - Frequency?_____________________
  - Amount?_____________________

- **Stress level of everyday life**
  - Slight
  - Moderate
  - High

- **Stress level of work life**
  - Slight
  - Moderate
  - High

- **Work environment type**
  - Sedentary
  - Active
  - Heavy Labor

## MEDICATION LIST

Please provide us with a list of medications you are currently taking. You may write your list below or attach a list. We do not have access to this information through the MyChart system to protect your privacy.

## INFORMED CONSENT / WAIVER OF LIABILITY

I understand that I am enrolling to participate in a fitness program at the Health Zone at Saint Francis. Despite the overall benefits of exercise, I understand that during exercise, there are risks. These may include but are not limited to, fainting, vomiting, musculoskeletal injury, heart attack and/or cardiac arrest, bodily injury or death.

The information, which is obtained during the course of this program, will be treated as personal and confidential. It will not be released without my consent. The information obtained, however, may be used for statistical purposes. This process will not identify individuals.

Information regarding my medical history may be requested from my personal physician. I understand that I am authorizing release to the physician listed above. I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance with this consent.

_to the best of my knowledge, all of the above statements are true._

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
<th>TIME</th>
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## HEALTH ZONE USE ONLY

<table>
<thead>
<tr>
<th></th>
<th>Member Number</th>
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<tbody>
<tr>
<td><strong>Guest pass</strong></td>
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<tr>
<td><strong>PREP Program</strong></td>
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<tr>
<td><strong>Member</strong></td>
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<tr>
<td><strong>Level I</strong></td>
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<tr>
<td><strong>Level II</strong></td>
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<tr>
<td><strong>Saint Francis Bridge Program</strong></td>
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<tr>
<td><strong>Staff Communication</strong></td>
<td>Left message</td>
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<tr>
<td><strong>Spoke to member by phone / in person</strong></td>
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<tr>
<td><strong>Emailed</strong></td>
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