HealthZone at Saint Francis

PERSONAL INFORMATION RECORD

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DATE

CLINICAL INFORMATION

LAST NAME		FIRST NAME		MI
DATE OF BIRTH	AGE ☐ Male ☐ Female	PHONE 1 ☐ HOME ☐ CELL ☐ WORK	PHONE 2 ☐ HOME ☐ CELL ☐ WORK	
PRIMARY CARE PHYSICIAN		OFFICE PHONE	OFFICE FAX	
EMERGENCY CONTACT		PHONE 2 ☐ HOME ☐ CELL ☐ WORK	PHONE 2 ☐ HOME ☐ CELL ☐ WORK	

EXERCISE HISTORY

Do you currently exercise regularly? ☐ No ☐ Yes, *specify type of activity:* ____________________

____

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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

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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.

SIGNATURE	DATE	TIME

HEALTH ZONE USE ONLY

☐ Guest pass	☐ PREP Program	☐ Member	MEMBER NUMBER
☐ Level I	☐ Level II	☐ Saint Francis Bridge Program ________	
Staff Communication	☐ Left message	☐ Spoke to member by phone / in person	☐ Emailed