Total Health
Stillwater Medical

Phone: 533-4348 Fax: 624-6596

Member Information and Health History

First Name: _____ Last Name: _____ MI: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F

Address _____City: _____State: _____ Zip: _____

Primary Phone: (____)_____ Secondary Phone: (_____)_____

E-mail:_____

Primary Care Physician: _____ Phone: _____

Specialist Physician: _____ Phone: _____

Emergency Contact: _____Relation:_____Phone:_____

Emergency Contact: _____Relation:_____Phone:_____

Regular physical activity is fun, healthy and safe for most people. However, some people may have health-related risks that require them to check with their physician prior to starting an exercise program. To help determine if there is a need for you to see your physician before starting an exercise program, please read the following questions and answer carefully. **All information will be confidential.**

Please mark all TRUE statements.

SECTION 1

You have had:

_____ A heart attack Year_____
_____ Heart surgery Year_____
_____Heart failure Year_____
_____ Stroke Year_____
_____ Cardiac catheterization Year_____
_____ Coronary angioplasty (PTCA) Year_____
_____ Pacemaker or Implantable defibrillator Year_____
_____ Rhythm disturbance Year_____
_____ Heart valve disease Year_____
_____ Heart transplant Year_____
_____ Congenital Heart disease Year_____

Symptoms:

_____You experience chest discomfort or chest pain with exertion or exercise
_____You have experienced chest pain when you were not doing physical activity
_____You experience unreasonable breathlessness
_____You experience dizziness, fainting, or blackouts
_____You take heart medications (for example, water pills) for blood pressure or heart condition
_____You experience ankle swelling
_____You experience unpleasant awareness of a forceful or rapid heart rate

Continue to the next page

Please mark all TRUE statements

Other health issue:

_____ You have diabetes
_____ You have asthma or other lung disease
_____ You have burning or cramping sensation in your lower legs when walking short distances
_____ You have musculoskeletal problems that limit your physical activity
_____ You have concerns about your safety while exercising
_____ You are pregnant

SECTION 2

Cardiovascular risk factors:

_____ You are a man: ≥45 years of age
_____ You are a woman: ≥55 years of age
_____ You currently smoke or use tobacco
_____ You quit smoking within the last 6 months
_____ You have high Blood Pressure (≥140/90) ____ don't know _____ take BP medication
_____ You have high Cholesterol (≥200) ____ don't know _____ take Cholest. Medication
_____ Have a father or brother who had a heart attack or heart surgery before age 55
_____ Have a mother or sister who had a heart attack or heart surgery before age 65
_____ You are diabetic or take medicine to control your blood sugar
_____ You are physically inactive (less than 30 min of physical activity for at least 3 days per week)
_____ You have a BMI ≥30 or a waist circumference ≥40 for men and ≥35 for women
_____ You are prediabetic

***If you marked two or more of the statements in this section, it is recommended that you consult your physician or other appropriate health care provider as part of good medical care and progress gradually with your exercise program. By initialing you agree that you have read and understand the statement above. Initial Here:_____**

SECTION 3

_____ Completed Physical Therapy in the last 12 months.
If yes, for what reason? _____ Who provided your therapy? _____

_____ Completed Cardiac Rehabilitation in the last 12 months.
If yes, for what reason? _____ Who provided your therapy? _____

_____ Currently being treated for a bone or joint problem that restricts your physical activity.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

_____ _____ _____
Name Signature Date