

Welcome to the Healthplex!

PROGRAM - Please check program that applies to you. If unsure, please ask our staff.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Aftercare | <input type="checkbox"/> Employee Health | <input type="checkbox"/> Pool | <input type="checkbox"/> Pulmonary Rehab |
| <input type="checkbox"/> Cardiac Rehab | <input type="checkbox"/> Health Improvement | <input type="checkbox"/> Prenatal/Post-Partum | <input type="checkbox"/> Lung Gym |
| <input type="checkbox"/> Cardiac Maintenance III, IV | <input type="checkbox"/> Senior Health | _____ (initial) | |

PERSONAL INFORMATION

TODAY'S DATE ___ / ___ / ___

Name: _____ Birthdate: ___ / ___ / ___ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____

Email Address: _____ Gender: Male Female

Race: White/Caucasian Hispanic Asian
(optional) Native American Black/African American Other

Employed Retired Disabled

Former or current occupation: _____

Marital Status: Single Married Widowed; Spouse's Name: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

PHYSICIAN CONTACTS

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Other Physicians (include specialty): _____ Phone: _____

HEALTH INSURANCE COMPANY: _____

HEALTH HISTORY QUESTIONNAIRE

1. Have you had any of the following heart or blood vessel conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Heart Transplant Surgery |
| <input type="checkbox"/> Angina (Chest Pain) | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Heart Valve Problem |
| <input type="checkbox"/> Angioplasty (PTCA) | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Implantable Defibrillator |
| <input type="checkbox"/> Angioplasty with Stent | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pericarditis |
| <input type="checkbox"/> Blood Clots _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bypass Surgery (CABG) | <input type="checkbox"/> Heart Rhythm Problems | <input type="checkbox"/> Other: _____ |

If you answered yes to any of the above, please explain (include dates when applicable)

2. Do you currently have or have you ever had any of the following signs or symptoms?

- | | | |
|--|---|--|
| <input type="checkbox"/> Angina, Chest Pain / Pressure | <input type="checkbox"/> Open Incision or Wound | <input type="checkbox"/> Inflamed Incision |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Leg Pain |
| <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> Palpitations | |

3. Do you have or have you ever had any of the following medical conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bone or joint issues | <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Other: _____ |

If you answered yes to any of the above, please explain (include dates when applicable)

4. Has a doctor told you that you have diabetes? Yes No

If yes, do you take insulin for your diabetes? Yes No

Do you check your blood sugar levels? Yes No

Last A1c: _____ Date: _____

5. Do you have any form of the following pulmonary (lung) illnesses?

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Bronchiectasis | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Pulmonary Fibrosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cor Pulmonale | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Tuberculosis |

Oxygen use: _____ liters/minute _____ hours/day Circle uses: Daytime Night With Activity

Type of home system _____ Type of Portable _____ Continuous Flow or Pulsed

6. Do you have problems sleeping at night? Yes No If yes describe: _____

Do you feel rested? ? Yes No

Name: _____ DOB: _____

7. Do you currently smoke cigarettes, cigars, pipes or use chewing tobacco? Yes No

If yes, do you want assistance to quit? Yes No

If you smoked in the past, what age did you start? _____ Age when quit: _____

What was/is the average number of packs per day you smoke(d)? _____

If you tried to quit smoking, what method(s) have you tried? _____

Does anyone smoke in your household? Yes No

8. Please check if the following apply to you:

____ You are a man older than 45 years

____ You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal

____ You smoke, or quit smoking within the previous 6 months

____ Your blood pressure is greater than 140/90 mm Hg

____ You do not know your blood pressure

____ You take blood pressure medication

____ Your cholesterol level is greater than 200 mg/dl

____ You do not know your cholesterol level

____ You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)

____ You are physically inactive (less than 30 minutes of physical activity on at least 3 days a week)

____ You are greater than 20 pounds overweight

9. Please circle any of the following conditions experienced by your immediate blood relatives:

Diabetes High Blood Pressure High Cholesterol Stroke

10. How would you rate your stress / anxiety level? Low Average High

Would you like to speak to a staff nurse about anxiety concerns? Yes No

11. Do you feel safe at home? Yes No

Would you like to speak to a nurse about safety concerns? Yes No

12. Have you fallen within the last 30 days or do you fall often? Yes No

Members are expected to provide their own attendant to assist with mobility needs while visiting or working out at the Healthplex. Please discuss with our exercise staff if this is an issue for you.

13. Pain: Are you having pain at this time? Yes No Location & Description: _____

Have you experienced pain or discomfort during exercise in the past? Yes No

If yes, please explain: _____

Name: _____ DOB: _____

14. Please name all of your medications, their dosages, and how often you take them:
(for example: Zocor, 5 mg, 1 time a day)

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

15. Allergies (include medication allergies): _____

16. Physical injuries / limitations: _____
Circle mobility aides you use: Cane Wheelchair Walker Crutches Braces Other: _____

17. Past surgeries (include dates): _____

18. Do you have any of the following problems that might affect your learning? Yes No
 Visual Hearing Reading Speech Learning

19. Would you like information about your conditions / illnesses / injuries? Yes No
If yes, please specify: Classes Handouts Videos One-on-One Learning

20. Please list other issues we should know about that might affect treatment and / or progress?
(i.e., language barriers, cultural or religious beliefs, scheduling, or transportation needs)

21. Please identify your personal fitness goals at the Healthplex:

Cardiovascular Fitness Goals

- Improve endurance of the heart and lungs
 Rehabilitation from heart surgery / procedure
 Improve activities of daily living _____

(Please list specific activities you would like to improve)

Strength Fitness Goals

- Physical independence
 Improve posture
 Reshape or tone body (improve muscular endurance)
 Injury prevention or rehabilitation or joint replacement issues
 Increase size of muscles or increase amount of weight lifted (improve strength)
 Improve sports / activity performance *Sport(s) / Activity:* _____
 Increase bone density (osteoporosis issues)

Additional Goals

- Improve flexibility Improve diet / eating habits Decrease body fat / weight loss
 Prepare for childbirth (i.e., strengthen back, etc.) Other _____

Pain Goal

Using a 0 to 10 scale, 0 being NO pain and 10 being the Worst Pain Possible, please specify the level of pain that is acceptable to you: _____

Presbyterian Healthplex EXERCISE PROGRAM Participant Agreement

Name of Participant: _____

I have enrolled to participate in the Presbyterian Exercise Program. The Program, including its anticipated benefits and risks, has been fully explained to me. I have been informed about the advisability of discussing the risks and benefits of participation with my physician and agree to request additional clarification and/or follow-up with my physician as may be necessary.

I agree to comply with all the rules and regulations of the Exercise Program and to accept full responsibility for my actions and any injuries that may result from my participation in the Program at the Presbyterian Healthplex.

I realize that there are certain associated risks with exercise that may occur during my physical activity regimen. I also realize that I will be able to ask questions and seek advice from staff at the Healthplex regarding my exercise prescription and behavior change strategy towards enhancing my health at the Presbyterian Healthplex.

I hereby release Presbyterian Healthcare Services, its officers, directors, employees and agents from any and all claims, demands, damages or liabilities in any way arising from or related to my participation in the Program.

I have read the foregoing and I understand it. Any questions that I raised have been answered to my satisfaction.

Date

Signature

Date

Witness