

Medical History Form



9950 CALUMET AVENUE, MUNSTER, IN 46321
 PHONE: (219) 924-5FIT
 FAX: (219) 924-8581

Date: _____ Date of Birth: _____ Age: _____

Name (PLEASE PRINT): _____

1) Have you had any recent hospitalizations within the last year? (Please circle) Yes No
 If yes, please describe:

2) Do you have any medical conditions? (Please circle) Yes No

If yes, please check appropriate conditions which apply to you:

<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Cigarette Smoking*
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	High Cholesterol*	<input type="checkbox"/>	Dizziness/Fainting
<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Joint Pain/Injury*
<input type="checkbox"/>	EKG Abnormalities	<input type="checkbox"/>	Leg Cramps with Exercise	<input type="checkbox"/>	Muscle Pain/Injury*
<input type="checkbox"/>	Cardiac Surgery	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>	Back Pain/Injury*
<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Leg Pain (PAD)	<input type="checkbox"/>	Recent Therapy Services
<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Arthritis*
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Asthma*	<input type="checkbox"/>	Bursitis*
<input type="checkbox"/>	Family History of Heart Disease*	<input type="checkbox"/>	Exercise Induced Asthma	<input type="checkbox"/>	Pregnant

3) Provide a brief explanation of ALL conditions checked above:

4) List ALL Medications:

Name of Medication	Purpose	Name of Medication	Purpose

5) *** MANDATORY INFORMATION NEEDED ***

Emergency Contact (Name): _____ Contact Number: _____

Physician's Name: _____ (If you DO NOT have a PHYSICIAN - write N/A)

City: _____ Phone: _____

I attest that the questions on this Medical Fact Sheet have been answered accurately,
 and give The Community Hospital Fitness PointeSM permission to
 contact my physician concerning "checked" conditions, which require additional information.
I understand that Fitness Pointe has the authority to make the final decision regarding my membership.

 Applicant's Signature

 Parent or Legal Guardian's Signature (If under 18)

FITNESS POINTE STAFF USE ONLY			
Approved: _____	Not Approved: _____	Date: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reason: _____
H	M	L	

TURN OVER