Medical History Form

The Community Hospital Fitness Pointe®
9950 Calumet Avenue, Munster, IN 46321
Phone: (219) 924-3FIT
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:

	Heart Conditions
	Heart Attack
	Heart Murmur
	EKG Abnormalities
	Cardiac Surgery
	Palpitations
	Chest Pains
	Stroke
	Family History of Heart Disease*

	High Blood Pressure
	High Cholesterol*
	Diabetes
	Leg Cramps with Exercise
	Ankle Swelling
	Leg Pain (PAD)
	Shortness of Breath
	Asthma*
	Exercise Induced Asthma

	Cigarette Smoking*
	Dizziness/Fainting
	Joint Pain/Injury*
	Muscle Pain/Injury*
	Back Pain/Injury*
	Recent Therapy Services
	Arthritis*
	Bursitis*
	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 Pointe[SM] 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: _____

☐ H ☐ M ☐ L Reason: _____

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