PRESBYTERIAN

Welcome to the Healthplex!

Program – Please check program that applies to you. If unsure, please ask our staff.

□ **Aftercare**	□ **Employee Health**	□ **Pulmonary Rehab**	□ **Lung Gym**
□ **Cardiac Rehab**	□ **Health Improvement**	□ **Prenatal/Post-Partum**	□ **Pool**
□ **Cardiac Maintenance**	□ **Cancer Rehab**	□ **Senior Health**	**_____(initial)**

PERSONAL INFORMATION **TODAY'S DATE** ___ / ___ / ___

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

Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____

Email Address: _____ Gender: □ Male □ Female

Race: (optional) □ **White/Caucasian** □ **Hispanic** □ **Asian** □ **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?

□ Aneurysm	□ Cardiomyopathy	□ Heart Transplant Surgery
□ Angina (Chest Pain)	□ Congenital Heart Disease	□ Heart Valve Problem
□ Angioplasty (PTCA)	□ Congestive Heart Failure	□ Implantable Defibrillator
□ Angioplasty with Stent	□ Coronary Artery Disease	□ Pacemaker
□ Atrial Fibrillation	□ Heart Attack	□ Pericarditis
□ Blood Clots _____	□ Heart Murmur	□ Stroke
□ Bypass Surgery (CABG)	□ Heart Rhythm Problems	□ Other: _____

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

_____

_____

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

□ Anemia	□ Epilepsy	□ Osteoarthritis
□ Back Pain	□ Fibromyalgia	□ Osteoporosis
□ Bone or joint issues	□ Gastroesophageal Reflux	□ Parkinson's Disease
□ Cancer	□ Kidney Disease	□ Rheumatoid Arthritis
□ Cerebral Palsy	□ Multiple Sclerosis	□ Urinary Problems
□ Chronic Fatigue	□ Muscular Dystrophy	□ 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?

□ Asthma	□ Emphysema	□ Pulmonary Hypertension
□ Bronchiectasis	□ Lung Cancer	□ Pulmonary Fibrosis
□ Bronchitis	□ Pleurisy	□ Sinusitis
□ COPD	□ Pneumonia	□ Sleep Apnea
□ Cor Pulmonale	□ Pulmonary Embolism	□ 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 _____ DOB: _____

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 regiment. 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**