

HEALTHPLEX MEMBER SCREENING QUESTIONNAIRE

Name: _____

Date: _____

Date of Birth: _____


Phone Number: _____

Phone: 823-8399 Fax: 823-8324

Yes	No
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—

1. Have you ever been told you have heart disease, any type of heart condition, OR do you take any medication for a heart problem?
2. Have either of your parents or any of your siblings ever had a stroke, heart disease, heart attack, coronary artery bypass surgery, or balloon angioplasty (PTCA) before they turned 55 (men) or 65 (women)?
3. Do you ever have chest pain or take medication for chest pain (Nitroglycerin)?
4. Do you ever feel dizzy, faint or lose your balance?
5. Do you have high blood pressure OR do you take medication for high blood pressure?
6. Do you have high cholesterol OR do you take medication for high cholesterol?
7. Do you have diabetes OR do you take medication for diabetes?
8. Do you have any pulmonary or lung disease OR do you take any medication for lung disease?
9. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
10. Do you know of any other reason why you should not do physical activity?

If you answered “**Yes**” to **ONE or more** of the above 10 questions, you may be able to safely perform any activity you desire, however:

 Presbyterian Healthplex requires physician authorization **prior to making your appointment** at the Healthplex.

 **Please bring this form to your Doctor for approval.**

If you answered “**No**” to **ALL** of the above questions, you can be reasonably sure you can take part in our fitness appraisal at the Healthplex. The gym staff will determine your basic fitness level and develop an individualized exercise prescription.

PHYSICIAN'S AUTHORIZATION TO PARTICIPATE:

Your patient has applied for enrollment in the exercise program at Presbyterian Healthplex. After reviewing this form and with your previous knowledge of his/her medical history, please indicate your recommendations below:

Physician Comments:

Physician Signature: _____

Member Signature: _____

PATIENT IDENTIFICATION

