

Medical Information

Name: _____

Phone (H): _____ Phone (W): _____

Address: _____

D.O.B. ___/___/___ Age _____ Weight _____ Height _____

All information requested on this form is necessary in order for us to guide you in your exercising needs. We guarantee you that all information is confidential and will not be forwarded to other organizations.

Please check all the following that applies to you, that have been either diagnosed or treated for by a physician or health professional:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes – Type 1 * | <input type="checkbox"/> Thyroid * |
| <input type="checkbox"/> Anemia, Sickle Cell | <input type="checkbox"/> Diabetes – Type 2 * | <input type="checkbox"/> Post-Partum ___mos. * |
| <input type="checkbox"/> Anemia, Other | <input type="checkbox"/> Emphysema * | <input type="checkbox"/> Lung Problem * |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcer * | <input type="checkbox"/> Muscular Problem * |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Epilepsy * | <input type="checkbox"/> Joint Problem * |
| <input type="checkbox"/> Congenital Defect * | <input type="checkbox"/> Bleeding Trait * | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Problem * | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Pregnant ___ wks.* | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Heart Problems * | <input type="checkbox"/> Cirrhosis, liver |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Stroke * | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Angina * | <input type="checkbox"/> Irregular Heart Rhythms * |
| <input type="checkbox"/> Other (Explain) | | |

In regards to any of the above, have you gotten your physician's approval to exercise? _____ If yes, when and what kind was recommended. _____

Have you had any surgery in regards to any of the above? Please explain, and list dates of surgery as well.

Please list your physician(s):

Name: _____ Phone: _____
Address: _____
Name: _____ Phone: _____
Address: _____

Please list all medications you are taking;

Name of Drug	What Purpose	Was This Prescribed?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all below that would apply to you:

- _____ Have not had a complete physical exam in the last 12 months.
- _____ Severe dieting (under 1,000 calories per day) *+
- _____ Smoking more than 20 cigarettes per day * ____; less than 20 per day x _____.
- _____ Have never exercised and under the age of 40.
- _____ Have never exercise and over the age of 40.
- _____ Have cardiovascular disease in immediate family.
- _____ Many times felt pain or dizzy during rest or exercise. *x
- _____ Get out of breath easily. *x
- _____ Often experience “heart burn” or pain in the chest. *
- _____ Experience “skipped” heart beats or unusual palpitations. *
- _____ Joints tend to swell. *
- _____ Have reoccurring pain in muscle or joints. *
- _____ Experience pain when exercising. *
- _____ Am 30+ pounds overweight. X
- _____ Experience numbness or tingling sensation in limbs. *
- _____ Have coughed up blood. *
- _____ Experienced abdominal pain. *x
- _____ Seem to lose control of muscles at times. *+
- _____ Feel “stiff” in the joints for several hours in the morning. x

Are there any other symptoms you’ve been experiencing that are not listed on this form, that we should know about? Explain

PLEASE READ CAREFULLY AND SIGN:

I understand that I am entering into an aerobic exercise program that challenges the cardiovascular and muscular systems. I understand that while I am engaging in exercise, there are risks of injury and perhaps other damages. These injuries can occur due to the load placed on muscle tissue, joints, heart, and lungs. I understand there will be an increase in blood pressure and heart rate during exercise. These injuries or damages could also occur as a result of my own work capability, flexibility, strength level, cardiovascular fitness, anatomical make-up and my own exercise technique as I interpret it. I understand that I will be participating in a group exercise setting in which I will have limited supervision. There will be additional risks such as tripping or perhaps collision. Therefore, I and all my associates and relatives agree to hold harmless Kathleen Conner Hi/Lo Aerobic Workout, its owner, associates, relatives, officers, instructors, other program participants, the sponsors of the program Cecil County Division of Parks & Recreation, and the exercise facility from any act of omission which may result in personal injury, property damage, or loss arising out of my participation in this program. I further indemnify all the above from all losses, costs, and expenses (including attorney's fees and court costs), settlement payments (whether reduced to final judgment) and all liabilities, damages, and fines paid, incurred, or suffered by Kathleen Conner's Hi/Lo Aerobic Workouts and its sponsors by reason of, injuries to person(s) (including death) or property damage caused by or attributed to my participation in this program.

I understand furthermore that I may voluntarily cease any exercise or activity of my own discretion at any time due to any concerns that I may have.

Signature _____ Date _____

In case of emergency, please notify: _____

Phone: _____ Cell: _____

Instructor's comments: _____

My signature hereby indicates that I have been advised to seek professional medical advise before participation in this program.

Signature _____ Date _____