FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Bangor Y Health Information Form

The information requested below is necessary in order to provide each member with a safe and appropriate exercise experience. All information will be kept strictly **confidential.**

Name: (Last)_____ (First)_____ (MI)_____ Today's Date _____
Daytime Phone: _____ Home Phone: _____
Address: _____ City: _____ Zip: _____
Email Address: _____ Gender: Male ___ Female ___
Date of Birth: _____ Age: _____ Height ____ ft ____inches
Weight:_____

General Medical Information
Date of Last Checkup: _____
Are you currently under a doctor's care? Yes ____ No ____ If yes, explain:
_____
Please list all physicians you are currently under the care of:
Physician: _____ Specialty:_____
Address: _____
Phone: _____

Most Recent Blood Pressure Reading: _____/_____ Date: _____

Do you currently exercise? Yes __ No __ If yes, please list activities and other recreational pursuits:
_____
Would you like more information about:
___ Orientation
___ Personalized Exercise Program
___ Personal Training
___ Personal Training in the pool
___ Biggest Mover

Do you accumulate 30 minutes or more of moderate physical activity on most days of the week? Y _N _
Does your job require you to sit or stand in one place for the majority of the time? Y __ N __

Have you ever had a stress test? Yes ___ (If yes, date: ___/___/___) No __ Don't know __
If yes, were the results: Normal ___ Abnormal ___ Don't know ___
Blood pressure response to exercise: Normal ___ Abnormal ___ Don't know ___

Do you take any medications on a regular basis? Yes ___ No ___
If yes, please list medications, dosage, and REASON FOR TAKING
_____ _____
_____ _____

If needed, can we call your physician for more information (please initial) _____
____ Yes, I give you my approval to contact my physician
____ No, I'd like to speak with you prior to contacting my physician

Office Use Only:

BANGOR Y
17 Second Street, Bangor ME 04401
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If you have been or are presently being treated for any of the following conditions please check yes or no. If you answer yes to any of those with an asterisk, please answer the appropriate section(s) on the following pages.

YES NO

___ ___ Heart disease: (circle) heart attack, bypass, cardiac surgery, artery disease, heart valve problems
___ ___ Congenital heart disease
___ ___ Rheumatic heart disease
___ ___ *Chest, neck, jaw, or arm pain/pressure/tightness/heaviness: with exertion __ at rest __
___ ___ Abnormal resting Electrocardiogram
___ ___ *Heart murmur
___ ___ *Irregular heart beat: rapid ___ slow ___ skipped beats ___ extra beats ___
___ ___ Stroke (if yes, date: ___/___/___)
___ ___ *Diabetes (fasting blood glucose ____mg/dl)
___ ___ *Other metabolic disease: thyroid ___ liver ___ kidney ___ other ___
___ ___ Epilepsy
___ ___ Abnormal blood pressure response to exercise
___ ___ High blood pressure (___/___ mm Hg)
___ ___ Elevated Cholesterol (>200 total, HDL <35, LDL > 130 or on cholesterol lowering medication):
Total: _____ mg/dl HDL _____ mg/dl LDL _____mg/dl
___ ___ Elevated triglycerides (present # ____/____mg/dl)
___ ___ Smoke cigarettes
___ ___ Quit smoking within the last 6 months
___ ___ Diagnosed hypoglycemia
___ ___ Anemia
___ ___Asthma: (if yes, please explain: _____)
___ ___ Obesity
___ ___ Pregnant (if yes, dates: _____)
___ ___ Osteoporosis
___ ___ *Arthritis
___ ___ *Joint or muscle pain/injury
___ ___ *Back pain or injury: upper back ___ middle back ___ lower back ___
___ ___ *Lightheadedness ___ or Fainting ___ (whichever applies)
___ ___ *Serious Illness
___ ___ *Surgery
___ ___ *Hospitalization

Family History:

(parents, siblings, or children before 55 years of age for males and before 65 years of age for females)

YES	NO		Family Member	Age of Onset
___	___	Heart disease (circle) heart attack, bypass surgery, cardiac surgery, artery disease	_____	_____
___	___	Sudden death	_____	_____
___	___	Congenital heart disease	_____	_____
___	___	Stroke	_____	_____

I understand that I am participating in an exercise program at my own risk and under the same terms mentioned on the membership form. I attest that I have voluntarily provided information for this form and that it is true to the best of my knowledge. I understand that I am responsible for updating this form annually or as health information changes, whichever comes first. I give employees of the Bangor Y permission to review my health information provided on this form. I understand that completion of this form does not impose any liability or obligation upon the Bangor Y.

Signature _____ Date ___/___/___ Witness _____ Date ___/___/___
Signature of Parent/Guardian if under 18 _____ Date ___/___/___

If you checked yes to conditions with an asterisk (*), please elaborate as much as possible. Please feel free to use the back if necessary.

1. Chest pain/pressure/tightness/heaviness
   Explain: _____
2. Heart murmur
   What is the diagnosis? _____
   When was it diagnosed? ____/____/____
   Is the condition still present? Yes ____ No ____
   How was it diagnosed? Stethoscope ____ Echocardiogram ____ Other _____
   Have you been restricted or limited in any way by your doctor Yes ____ No ____
   If yes, explain:_____
3. Irregular heart beat
   Explain: _____
4. Diabetes
   Do you take insulin shots? _____
   Is it controlled by diet? _____
   Any restrictions/limitations? _____
   Any other important information? _____
   Do you take medications? If so, what? _____
5. Metabolic Disease
   When were you diagnosed? ____/____/____
   Is the condition still present? Yes ____ No ____
   Any restrictions/limitations? _____
6. Arthritis
   Where is it located? _____
   Has it been diagnosed by a doctor? _____
   Any restrictions/limitations? _____
   Are there certain activities which aggravate the condition? _____
7. Joint or muscle pain/injury
   Which joint? _____ Which muscle? _____
   When and how did the injury occur? _____
   What type of doctor was seen? General Practitioner __ Orthopedist __ Physical Therapist __Other __
   What was the diagnosis? _____
   Are you still in treatment? _____
   Any restrictions/limitations? _____
8. Back pain/injury
   Describe pain _____
   What type of doctor was seen? General Practitioner __ Orthopedist __Physical Therapist __Other __
   What was the diagnosis? _____
   Are you still in treatment? _____
   Any restrictions/limitations? _____
9. Lightheadedness or fainting
   What is the cause? _____
   Have you seen a doctor? _____
   How long have you had this condition? _____
   How often do episodes occur? _____
10. Allergies – What are they? _____
    Please provide any other details _____
11. Serious Illness
    Please describe (what, when): _____
    _____
12. Surgery – Please describe (what, when): _____
    _____
13. Hospitalization – Please describe (what, when): _____
    _____