Information and Health History Form

Name: ___________________________________ Date: _______________
Address (street, city, zip code): ____________________________________
Home Phone: ____________________ Cell Phone: ___________________
Email: ____
Employment (company, position) _________________________________
Date of Birth ___________________ Age ______ Gender ________
Person to Contact In case of emergency _____________________________
Phone_____________________ Relationship _______________

Do you know or have you had in the past….

1. A history of heart problems in immediate family? Y N
   If so how old were they at onset? ________
2. Cigarette smoking or other tobacco use? Y N
3. Elevated blood pressure or taking blood pressure medications? Y N
4. High cholesterol, triglycerides, or on lipid lowering medications? Y N
5. Diabetes or thyroid condition, impaired glucose? Y N
6. Any chronic illness or condition? Y N

Please explain:____

7. Difficulty with physical exercise? Y N
8. Advice from medical professional not to exercise? Y N
9. Recent surgery (in past 12 months)? Y N

Please list:____

10. Pregnancy (now or in last three months)? Y N
11. History of allergy, breathing or lung problems? Y N
12. Muscle, joint or back disorder? Y N

Please explain____

13. Any previous injuries still affecting you? Y N

Please explain:____

Name: ______________________________

14. Do you have pain, discomfort or other angina equivalent in the chest, neck, jaw, arms, or other areas that might be caused by lack of blood flow? Y N
15. Shortness of breath at rest or mild exertion? Y N
16. Dizziness or fainting? Y N
17. Troubled or rapid breathing at night or the need to sit up to breathe? Y N
18. Ankle or leg swelling? Y N
19. Rapid heartbeat or palpitations? Y N
20. Calf or leg cramping? Y N
21. A known heart murmur? Y N
22. Unusual fatigue or shortness of breath with daily activities? Y N
23. Other concerns we should be aware of? Y N

Please explain:____

What is your current level of activity (work & leisure)?
____

Are you currently involved in any regular exercise program? Y N
Please describe: ____
____

Are you taking any drugs, vitamins, herbs, medicinal cannabis or other supplements? Y N ____

Current Weight?__________ What is your ideal weight? ________

Are you seeing a specialist or therapist? Y N

Reason:____

Name:________________________________ Phone: _____________________

Office Location and Name ____

Physicians Name:________________________ Phone:_________________

Office Location____

Does your physician or specialist know you are participating in this program? Y N

Name: ________________________

What brought you to Evergreen Swims?

____

____

What are your Aquatic Goals?

____

____

____

Office Use Only:

Discussed and Reviewed by: ____

Signature:____

Date: ________________________________

Notes: