Ephrata Recreation Center
Health History Form

Personal Information	
Last Name:	First Name:
Address:	
Date of Birth:	Age:
Height	Weight:
Sex:	Contact Phone:
e-mail:	Alt. E-mail:
Emergency Contact Info: (name/phone)	
Physicians Name and Address:	

Current Medication		
Medication	Dosage	Reason

Please Respond to the Following:

Yes	No	
		Is your resting blood pressure greater than 140/90?
		Have you ever been told you have high blood pressure?
		Have you ever been told you have coronary heart disease?
		Do you ever feel dizzy, short of breath, or have chest pain on exertion? (circle all that apply)
		Have you ever had heart surgery, angioplasty or cardiac catheterization? (circle all that apply)
		Have you ever suffered from angina, stroke, heart attack, cardiovascular disease or pulmonary disease? (circle all that apply)

		Have you ever experienced unusual heart beats such as skipped beats or palpitations?
		Do you have diabetes? If so, how is it controlled?
		Do you drink caffeine beverages? If so please list:
		Is your cholesterol greater than 200?
		Have you ever been told your cholesterol is or was abnormal?
		Do you drink soda or sugar flavored drinks?
		Did/do your parents or siblings have history of cardiovascular disease, such as heart disease, stroke, angina, high blood pressure, diabetes, etc. Is so, specify which
		Do you feel you are greater than 10 pounds overweight?
		Do you have asthma, bronchitis, or other lung disorder? (circle all that apply)
		Have you ever had a seizure?
		Do you have arthritis or bursitis?
		Are you currently exercising? If so, specify.
		Do you have any medical or physical limitations we need to know about? Please explain.
		Have you had any recent injuries or illnesses? Explain.
		Do you have any exercise limitations? Explain.
		Are you pregnant?
		When was your last physical exam?

"Success seems to be connected with action. Successful people keep moving. They make mistakes, but they don't quit."

– *Conrad Hilton*