

MEMORIAL PARK NATATORIUM

HEALTH HISTORY FORM

NAME: _____ AGE: _____ SEX: _____ PHONE NO.: _____

PHYSICIAN: _____ PHYSICIAN PHONE NO: _____

EMERGENCY CONTACT PERSON: _____ PHONE NO: _____

MEDICATIONS: _____

List physical activities you participate in regularly:

1. _____ 2. _____ 3. _____

	YES	NO
1. Has a doctor ever said your blood pressure was too high?	_____	_____
2. Has a doctor ever said you have heart trouble?	_____	_____
3. Has a doctor ever advised you not to exercise? If yes, why? _____	_____	_____
4. Do you frequently have pains in your chest?	_____	_____
5. Do you frequently feel faint or have dizzy spells?	_____	_____
6. Do you have difficulty with physical exercise?	_____	_____
7. Do you have a chronic illness? List: _____	_____	_____
8. Do you have a history of lung or respiratory problems?	_____	_____
9. Do you have diabetes?	_____	_____
10. Do you smoke? If yes, number of packs a day: _____	_____	_____
11. Do you have high blood cholesterol?	_____	_____
12. Are you more than 30 lbs. overweight?	_____	_____
13. Have you had surgery within the past 3 months? If yes, explain: _____	_____	_____
14. Do you have any orthopedic problems that may be aggravated with physical activity? If yes, list: _____	_____	_____
15. Are you pregnant?	_____	_____

SIGNATURE: _____

DATE _____