



# HEALTH HISTORY FORM

Mercy Fitness Center

5264 Council St. NE, Suite 600

Cedar Rapids, IA 52402

Phone: 319.221.8877 Fax: 319.398.6543

Name: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

Street

City/Town

State

Zip

Phone: (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_ E-mail: \_\_\_\_\_

Gender: M F Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Person to contact in case of an emergency:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### IF APPLICABLE, PLEASE COMPLETE – Required for Prenatal Yoga Registration

Have you been pregnant within the past 3 months?	yes	no	(circle one)
Have you been pregnant before?	yes	no	(circle one) If yes, have you ever had?
_____ History of 3 or more spontaneous abortions		_____	Incompetent cervix
_____ Ruptured membranes		_____	Bleeding or placenta previa
_____ Pre-mature labor		_____	Constrictive lung disease
_____ Multiple fetuses		_____	Cardiac disease

### Current medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Purpose

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Do you have or have you had:

YES

NO

If yes, please explain

- |    |  |       |       |       |
|----|--|-------|-------|-------|
| 1. | A history of heart problems?                           | _____ | _____ | _____ |
| 2. | A history of high blood pressure?                      | _____ | _____ | _____ |
| 3. | Difficulty with exercise,<br>i.e. shortness of breath? | _____ | _____ | _____ |
| 4. | A chronic illness?                                     | _____ | _____ | _____ |
| 5. | Advice from a physician not to exercise?               | _____ | _____ | _____ |
| 6. | Recent surgery (within the past 3 months)?             | _____ | _____ | _____ |
| 7. | Diabetes?  | _____ | _____ | _____ |
|    | If yes, do you take insulin?                           | _____ | _____ | _____ |
| 8. | History of heart problems<br>in your immediate family? | _____ | _____ | _____ |

- |  | <u>YES</u> | <u>NO</u> | <u>If yes, please explain</u>  |
|--|------------|-----------|--|
| 9. History of lung problems, i.e., chronic bronchitis, emphysema, asthma.                    | _____      | _____     | If yes what: _____<br>If yes when: _____   |
| 10. Cigarette smoking within six months?<br>packs per day? _____                             | _____      | _____     | If yes how many  |
| 11. Have you had or presently have problems with your eyes (i.e. cataracts, glaucoma, renal) | _____      | _____     | _____  |
| 12. Have you ever been told you have high blood cholesterol?                                 | _____      | _____     | If yes, what is it? _____  |
| 13. What is your approximate weight and height?  | _____      | _____     | Weight: _____ Height: _____<br>(more than 25 pounds overweight? Yes No – circle one) |
| 14. Have you ever had seizures? (Epileptic or other)   | _____      | _____     | _____  |
| 15. Muscle, joint, or back disorder that could be aggravated by physical activity?           | _____      | _____     | _____  |
| 16. Any other significant medical information not mentioned above?                           | _____      | _____     | _____  |
| 17. Are you currently involved in a regular exercise program?<br>If yes, what and how often? | _____      | _____     | _____  |
| 18. Do you have a Latex sensitivity?   | _____      | _____     | _____  |

19. Do you give permission for Mercy Fitness Center to disclose the above health information to your physician to assist us in making recommendations regarding your exercise program? Yes \_\_\_\_\_ No \_\_\_\_\_

I certify that the information provided is true, correct and complete. I fully realize that my participation in the exercise program(s) offered by Mercy Fitness Center could result in overexertion or bodily injury to myself. However, I have entered into this group and will participate in said program(s) of my own accord and hereby agree to release from all liability and hold harmless Mercy Medical Center, Inc. d/b/a Mercy Fitness Center, and its officers, employees and agents. I hereby agree that I will follow all prescribed screening procedures upon entering this program and adhere to all program guidelines.

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_  
Date Date

**ACKNOWLEDGEMENT:**

**I hereby acknowledge receipt of the MercyCare Service Corporation's Joint Notice of Privacy Practices.**

Patient Name: \_\_\_\_\_  
(Please Print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Legal Representative)

\_\_\_\_\_  
(Relationship if not the Patient)