CAPITAL REGION HEALTHPLEX
University of Missouri Health Care

HEALTHPLEX
MEDICAL HISTORY QUESTIONNAIRE
(Completed by all NEW members)

Name____ Date: __________________________

Date of Birth__________________ Phone # ____

As a matter of policy, we must have all participants fill out a health risk questionnaire. Common sense is your best guide when you answer these questions. Please read questions carefully.

YES NO 1. Has your doctor ever said you have a heart or lung problem? __________________________
YES NO 2. Do you have any signs or symptoms of heart disease such as chest pain, shortness of breath, unexplained dizziness, or lightheadedness? ______________________________________
YES NO 3. Do you have diabetes? ____
YES NO 4. Are you pregnant? ____
YES NO 5. Are there any bone, back, or joint problems or recent surgeries that could be made worse by a change in your activity level? ie. arthritis, osteoporosis, disc disease, rotator cuff, etc. explain:____
YES NO 6. Are you being treated by a doctor for any other illness that may be affected by an exercise program? ie. cancer, kidney disease, ____

If you answered “yes” to any of the questions 1-6, a physician clearance form is required for program participation.

YES NO 7. Family History: Has your mom, dad, brother or sister been diagnosed with heart disease before age 55 for a male and age 65 for a female.
YES NO 8. High Blood Pressure: Do you have high blood pressure or are you taking medications to control your blood pressure?
YES NO 9. High Blood Cholesterol: Is your total cholesterol over 200 and/or LDL over 130 or do you not know your cholesterol numbers.
YES NO 10. Smoker: Do you currently smoke or did you quit and it has not been over 6 months yet?
YES NO 11. Inactivity: Do you engage in less than 90 minutes of exercise per week?
YES NO 12. Age: Are you a male over the age of 45, or a female over the age of 55?
YES NO 13. Have you fallen in the past 6 months?

If you answered “yes” to two or more of the questions 7-12, a physician clearance form is required for program participation.

Physician Name (please print):____________________________ Phone:____________ Fax:_____________

I hereby certify that the above information is true and correct to the best of my knowledge.

I authorize Capital Region Medical Center (CRMC) to contact my physician as stated above, for consent for me to participate in an exercise program at Capital Region Healthplex.

Member Signature:____________________________ Witness (HP Staff):______________________________

Reviewed by: ________________________________

PHYSICIAN CLEARANCE FORM

Confidential Fax Date:________________

List Restrictions: ____

"Based upon my medical knowledge of this patient and subject to any restrictions listed above, I am unaware of any condition that would preclude he/she from participating in an exercise program."

Physician Signature: X____ Date: _______________

If you have any questions or concerns or would like to inquire about other services that we offer, please contact us at 573-632-5634. Return fax: 573-632-5990 Mailing Address: P.O. Box 1128, Jefferson City, MO 65102-1128