PRESBYTERIAN

Name: _____ **Date:** _____

Date of Birth: _____ **Phone Number:** _____

Healthplex Member Screening Questionnaire

Phone: 823-8399 Fax: 823-8324

Yes	No	
___	___	1. Have you ever been told you have heart disease, any type of heart condition, OR do you take any medication for a heart problem?
___	___	2. Have either of your parents or any of your siblings ever had a stroke, heart disease, heart attack, coronary artery bypass surgery, or balloon angioplasty (PTCA) before they turned 55 (men) or 65 (women)?
___	___	3. Do you ever have chest pain or take medication for chest pain (Nitroglycerin)?
___	___	4. Do you ever feel dizzy, faint or lose your balance?
___	___	5. Do you have high blood pressure OR do you take medication for high blood pressure?
___	___	6. Do you have high cholesterol OR do you take medication for high cholesterol?
___	___	7. Do you have diabetes OR do you take medication for diabetes?
___	___	8. Do you have any pulmonary or lung disease OR do you take any medication for lung disease?
___	___	9. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
___	___	10. Do you know of any other reason why you should not do physical activity?

If you answered "**Yes**" to **ONE or more** of the above 10 questions, you may be able to safely perform any activity you desire, however:

- Presbyterian Healthplex requires physician authorization **prior to making your appointment** at the Healthplex.
- **Please bring this form to your Doctor for approval.**

If you answered "**No**" to **ALL** of the above questions, you can be reasonably sure you can take part in our fitness appraisal at the Healthplex. The gym staff will determine your basic fitness level and develop an individualized exercise prescription.

PHYSICIAN'S AUTHORIZATION TO PARTICIPATE:
Your patient has applied for enrollment in the exercise program at Presbyterian Healthplex. After reviewing this form and with your previous knowledge of his/her medical history, please indicate your recommendations below:
Physician Comments:

Physician Signature: _____

Member Signature: _____