Fitness Center

Burke Rehabilitation Hospital l Adult Fitness Center
P: 914.597.2805 F: 914.597.2809
785 Mamaroneck Ave. White Plains NY 10605

Medical History Update

Dear member, in an effort to keep your health history current, we would like you to complete this form and return to the gym. These updates allow us to continue to create safe, effective and individualized exercise programs.

Name:_____ Nickname: _____
Address: _____ City/State/Zip: _____
DOB: ___/____/_____ Gender: _____ Primary Phone: _____
Email: _____

Exercise Readiness Questionnaire	Yes	No
Are you over the age of 65 and not accustomed to vigorous exercise?		
Do you have frequent pains in your heart and chest?		
Do you often feel faint or have spells of severe dizziness?		
Has your doctor ever told you your blood pressure was too high?		
Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise?		
Is there a good physical reason why you should not exercise even if you wanted to?		

Please Select All Known Health Conditions That May Apply

	Cardiovascular	Date
	Chest Discomfort	
	Current Heart Murmur	
	Extra, Skipped or Rapid Heart beat	
	Heart Attack	
	High Blood Pressure	
	High Cholesterol	
	Low Blood Pressure	
	Peripheral Vascular Disease	
	Phlebitis or Emboli	
	Rheumatic Fever	
	Stroke	
	Pacemaker or Defibrillator	
	Cardiovascular Surgery	
	Cardiac Arrhythmia	
	Aortic Stenosis	
	Congestive Heart Failure	
	Pulmonary	
	Allergies	
	Asthma	
	Asthma (Exercise Induced)	
	Bronchitis or Chronic Bronchitis/Emphysema	
	Chronic Recurring Cough	
	Emphysema	
	Pneumonia	
	Pulmonary Edema	
	Pulmonary Hypertension	

	Musculoskeletal	Date
	Ankle Swelling	
	Back Problems	
	Broken Bones (Recent ≤ 1 yr)	
	Fibromyalgia	
	Foot Problems	
	Limited Motion in Joints	
	Lupus	
	Neck Problems	
	Osteoarthritis	
	Osteoporosis	
	Rheumatoid Arthritis	
	Shoulder Problems	
	Recent Surgery	
	Swollen, Sore, Painful Joints	
	Other	
	Anemia	
	Depression	
	Diabetes	
	Epilepsy or Seizures	
	Hearing Impairment	
	Parkinson's	
	Post-Natal	
	Pregnant	
	Cancer	
	Positive TB Test?	
	Oxygen Therapy (___L/min)?	

RISK REVIEW

Medical History Update

Name: _____ Phone:_____ Date:___/___/____

Risk Factor	ACSM RISK FACTOR DEFINING CRITERIA	YES	NO	NOT SURE
Age	Are you a male over the age of 55 or a female over the age of 65?			
Family History	Has there been a heart attack, coronary bypass, or sudden death before age 55 in father or male first-degree relative (i.e. brother or son) or in mother before age 65 or other female first degree relative (i.e. sister or daughter)?			
Cigarette Smoking	Are you a current cigarette smoker or have you quit within the previous 6 months?			
High Cholesterol (Dyslipidemia)	Has your doctor prescribed medication to lower your cholesterol?			
Fasting Glucose	Have there been any abnormal fasting glucose measurements on at least 2 separate occasions?			
Obesity	Is your waistline over 40 inches if you are male or 35 inches if you are female?			
High Blood Pressure	Has your doctor prescribed medication to control your blood pressure, or, have you had a blood pressure measurement over 140/90 on at least 2 separate occasions?			
Sedentary Lifestyle	Are you participating in a regular exercise program or do you participate in 30 minutes of aerobic activity most days of the week?			

Table 2- Have you had any of the following symptoms recently?	YES	NO	NOT SURE
Pain, discomfort in the chest, neck, jaw, arms or other areas during exertion?			
Shortness of breath during rest or mild exertion?			
Dizziness?			
Rapid extra heart beats you can feel?			
Significant pain in the lower legs at rest or mild activity (pain level makes you stop)?			
Ankle Swelling?			
Do you have a known heart murmur?			
Unusual fatigue or shortness of breath with usual activities?			

PLEASE LIST ANY MEDICATIONS AND DIETARY SUPPLEMENTS YOU ARE TAKING

1._____2. _____ 3. _____4._____

5._____ 6. _____ 7. _____ 8. _____

Notes: _____