PRESBYTERIAN

Welcome to the Healthplex!

PROGRAM - Please check program that applies to you. If unsure, please ask our staff.

☐ Aftercare ☐ Employee Health ☐ Pool ☐ Pulmonary Rehab
☐ Cardiac Rehab ☐ Health Improvement ☐ Prenatal/Post-Partum ☐ Lung Gym
☐ Cardiac Maintenance III, IV ☐ Senior Health ________ (initial)

PERSONAL INFORMATION **TODAY'S DATE** ___ / ___ / ___

Name: ______________________________________ Birthdate: ___ / ___ / ___ Age: ______

Address: ____

City: ______________________________ State: ____________________ Zip: ______________

Phone: (home) ______________________________ (work) ______________________________

Social Security Number: _______ / _______ / _______ Gender: ☐ Male ☐ Female

Race: ☐ White/Caucasian ☐ Hispanic ☐ Asian
(optional) ☐ Native American ☐ Black/African American ☐ Other

☐ Employed ☐ Retired ☐ Disabled

Former or current occupation: ____

Marital Status: ☐ Single ☐ Married ☐ Widowed; Spouse's Name: ___________________

Emergency Contact Name: ____

Phone: __________________________________ Relationship: ___________________________

PHYSICIAN CONTACTS

Primary Care Physician: _______________________________ Phone: ________________

Referring Physician: ___________________________________ Phone: ________________

Other Physicians (include specialty): ______________________ Phone: ________________

HEALTH INSURANCE COMPANY: ____

HEALTH HISTORY QUESTIONNAIRE

1. Have you had any of the following heart or blood vessel conditions?

☐ Aneurysm
☐ Angina (Chest Pain)
☐ Angioplasty (PTCA)
☐ Angioplasty with Stent
☐ Atrial Fibrillation
☐ Blood Clots ___________
☐ Bypass Surgery (CABG)
☐ Cardiomyopathy
☐ Congenital Heart Disease
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Heart Attack
☐ Heart Murmur
☐ Heart Rhythm Problems
☐ Heart Transplant Surgery
☐ Heart Valve Problem
☐ Implantable Defibrillator
☐ Pacemaker
☐ Pericarditis
☐ Stroke
☐ Other: _______________

If you answered yes to any of the above, please explain (include dates when applicable)

____

____

2. Do you currently have or have you ever had any of the following signs or symptoms?

☐ Angina, Chest Pain / Pressure
☐ Dizziness / Fainting
☐ Swelling of Ankles
☐ Open Incision or Wound
☐ Shortness of Breath
☐ Palpitations
☐ Inflamed Incision
☐ Leg Pain

3. Do you have or have you ever had any of the following medical conditions?

☐ Anemia
☐ Back Pain
☐ Bone or joint issues
☐ Cancer
☐ Cerebral Palsy
☐ Chronic Fatigue
☐ Epilepsy
☐ Fibromyalgia
☐ Gastroesophageal Reflux
☐ Kidney Disease
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson's Disease
☐ Rheumatoid Arthritis
☐ Urinary Problems
☐ Other: ____________

If you answered yes to any of the above, please explain (include dates when applicable)

____

____

4. Has a doctor told you that you have diabetes? ☐ Yes ☐ No

   If yes, do you take insulin for your diabetes? ☐ Yes ☐ No

   Do you check your blood sugar levels? ☐ Yes ☐ No

   Last A1c: ________ Date: ________

5. Do you have any form of the following pulmonary (lung) illnesses?

☐ Asthma
☐ Bronchiectasis
☐ Bronchitis
☐ COPD
☐ Cor Pulmonale
☐ Emphysema
☐ Lung Cancer
☐ Pleurisy
☐ Pneumonia
☐ Pulmonary Embolism
☐ Pulmonary Hypertension
☐ Pulmonary Fibrosis
☐ Sinusitis
☐ Sleep Apnea
☐ Tuberculosis

   Oxygen use: ____ liters/minute _____ hours/day Circle uses: Daytime Night With Activity
   Type of home system __________ Type of Portable __________ Continuous Flow or Pulsed

6. Do you have problems sleeping at night? ☐ Yes ☐ No If yes describe: _______________

____

   Do you feel rested? ? ☐ Yes ☐ No

Name: ____ DOB: ___________________

7. Do you currently smoke cigarettes, cigars, pipes or use chewing tobacco? ☐ Yes ☐ No

   If yes, do you want assistance to quit? ☐ Yes ☐ No

   If you smoked in the past, what age did you start? _______ Age when quit: ____________

   What was/is the average number of packs per day you smoke(d)? ______________________

   If you tried to quit smoking, what method(s) have you tried? __________________________

   Does anyone smoke in your household? ☐ Yes ☐ No

8. Please check if the following apply to you:

   ____ You are a man older than 45 years

   ____ You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal

   ____ You smoke, or quit smoking within the previous 6 months

   ____ Your blood pressure is greater than 140/90 mm Hg

   ____ You do not know your blood pressure

   ____ You take blood pressure medication

   ____ Your cholesterol level is greater than 200 mg/dl

   ____ You do not know your cholesterol level

   ____ You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)

   ____ You are physically inactive (less than 30 minutes of physical activity on at least 3 days a week)

   ____ You are greater than 20 pounds overweight

9. Please circle any of the following conditions experienced by your immediate blood relatives:

   Diabetes   High Blood Pressure   High Cholesterol   Stroke

10. How would you rate your stress / anxiety level? ☐ Low ☐ Average ☐ High

    Would you like to speak to a staff nurse about anxiety concerns? ☐ Yes ☐ No

11. Do you feel safe at home? ☐ Yes ☐ No

    Would you like to speak to a nurse about safety concerns? ☐ Yes ☐ No

12. Have you fallen within the last 30 days or do you fall often? ☐ Yes ☐ No

    Members are expected to provide their own attendant to assist with mobility needs while visiting or working out at the Healthplex. Please discuss with our exercise staff if this is an issue for you.

13. Pain: Are you having pain at this time? ☐ Yes ☐ No Location & Description: ________

    ____

    Have you experienced pain or discomfort during exercise in the past? ☐ Yes ☐ No

    If yes, please explain: ____

Name: ____ DOB: ___________________

14. Please name all of your medications, their dosages, and how often you take them:
(for example: Zocor, 5 mg, 1 time a day)

______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

15. Allergies (include medication allergies): ______________________

16. Physical injuries / limitations: ______________________
Circle mobility aides you use: Cane Wheelchair Walker Crutches Braces Other: _________

17. Past surgeries (include dates): ______________________
____

18. Do you have any of the following problems that might affect your learning? ☐ Yes ☐ No
☐ Visual ☐ Hearing ☐ Reading ☐ Speech ☐ Learning

19. Would you like information about your conditions / illnesses / injuries? ☐ Yes ☐ No
If yes, please specify: ☐ Classes ☐ Handouts ☐ Videos ☐ One-on-One Learning

20. Please list other issues we should know about that might affect treatment and / or progress?
(i.e., language barriers, cultural or religious beliefs, scheduling, or transportation needs)

21. Please identify your personal fitness goals at the Healthplex:

Cardiovascular Fitness Goals
- ☐ Improve endurance of the heart and lungs
- ☐ Rehabilitation from heart surgery / procedure
- ☐ Improve activities of daily living ______________________
(Please list specific activities you would like to improve)

Strength Fitness Goals
- ☐ Physical independence
- ☐ Improve posture
- ☐ Reshape or tone body (improve muscular endurance)
- ☐ Injury prevention or rehabilitation or joint replacement issues
- ☐ Increase size of muscles or increase amount of weight lifted (improve strength)
- ☐ Improve sports / activity performance *Sport(s) / Activity*: ______________
- ☐ Increase bone density (osteoporosis issues)

Additional Goals
- ☐ Improve flexibility ☐ Improve diet / eating habits ☐ Decrease body fat / weight loss
- ☐ Prepare for childbirth (i.e., strengthen back, etc.) ☐ Other __________

Pain Goal
Using a 0 to 10 scale, 0 being NO pain and 10 being the Worst Pain Possible, please specify the level of pain that is acceptable to you: ____________

Name: ______________________________ DOB: ____________