

Health Screening Form

Name _____ Date _____ Home Phone _____

Male _____ Female _____ Age _____ Height _____ Weight _____

This form is intended to obtain relevant information about your health that will assist staff in helping you with your fitness assessment and/or exercise program. Please answer all questions to the best of your knowledge.

1. Have you ever been **diagnosed with hypertension** (high blood pressure)? YES NO
2. Have you ever had a **blood pressure reading** higher than 160/90 on at least two separate occasions? YES NO
3. Are you currently on **antihypertensive** (high blood pressure) **medication**? YES NO
4. Have you ever had a **cholesterol** reading above 240? YES NO
5. Do you currently **smoke**? YES NO
6. Do you have **Diabetes Mellitus**? YES NO
If yes, are you insulin dependent? _____ How long? _____
7. Do you have any **siblings or parents** that have had heart attacks, heart disease or other atherosclerotic disease prior to age 55? YES NO
8. Have you ever had **chest pain, heart attack, heart disease or other atherosclerotic disease**? YES NO
9. Do you have any serious **orthopedic problems** that would prevent you from exercising? YES NO
10. Do you have any reason to believe that you should not exercise? YES NO
11. Please list any **medications** that you are currently taking and any **allergies** that you might have:

12. Please list the person that you would like us to contact in the event of an emergency:

Name: _____ Phone: _____

Relation: _____ Address: _____

Fax to: DCRC
ATTN: T.J. Putnam
614-761-6545

Mail to: DCRC
ATTN: T.J. Putnam
5600 Post Road
Dublin, Ohio 43017

For questions please contact:
T.J. Putnam
Fitness & Wellness Coordinator
614-410-4584