☐ **Old Bridge YMCA** Date:_____
1 Mannino Park Drive
Old Bridge, New Jersey
(732) 727-0704

☐ **YMCA of Western Monmouth County**
470 East Freehold Road
Freehold, New Jersey
(732) 462-0464

HEALTH & MEDICAL QUESTIONNAIRE

Name:_____ Address:_____

City: _____ State: _____ Zip Code:_____ Email:_____

Date of Birth:_____/_____/_____ Age:____ Sex: M___F___

Cell Phone:_____ Other:_____

Emergency Contact:

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Physician:
Name:_____ Phone :_____Fax:_____

Specialist (PT, Cardiologist, etc.):_____

Phone:_____Fax:_____

Please list any medications you are taking and the reason:

Medications	Purpose

FOR OFFICE USE ONLY

	Date	Time	Instructor	Complete	N/S	Canc.	Rescheduled
Cybex							
Fitness Center							
Free Weights							

Date Received: _____ 1st call _____ 2nd call _____ 3rd call _____

PLEASE CHECK YES OR NO

PAST HISTORY (Have you ever had?)	YES	NO
Heart Attack or Stroke	____	____
High blood pressure	____	____
Elevated Cholesterol	____	____
Any heart trouble	____	____
Disease of the arteries	____	____
Lung disease	____	____
Asthma	____	____
Diabetes	____	____
Heart murmur	____	____
Arthritis	____	____
Smoked & # of years	____	____
Surgery	____	____
Other:		

PRESENT SYMPTOMS (Have you recently had?)	YES	NO
Chest pain/discomfort	____	____
Shortness of breath	____	____
Irregular heartbeat	____	____
Frequent headaches	____	____
Dizziness	____	____
Smoking	____	____
Back pain/injury	____	____
Pregnant	____	____
Bone or Joint problems	____	____
Overweight by 20+lbs	____	____
Other:_____		

If you are over the age of 69 you may want to consider a physician's referral prior to working out whether or not you have answered "YES" to any questions.

If you answered* YES *to one or more of the previous questions...
Please have your doctor fill out the following physician referral form. This form must be signed by your physician and returned to us before we can begin your program. Please inform your doctor about this Health History Evaluation and to which questions you answered yes.

If you answered* NO *to all of the previous questions...
You can be reasonably sure that you can partake in fitness activities.

The above information is true to the best of my knowledge.
I hereby, for myself, my heirs, administrators, executors and assigns, release the YMCA of Western Monmouth & Old Bridge YMCA to be accepted and permitted to participate in a program of exercise. In consideration of being accepted to this program based on the Health History Evaluation I have completed on behalf of myself, I release and discharge the YMCA of Western Monmouth County & Old Bridge YMCA and any of its agents participating in said program from any claims or demands which I may have now or at any time in the future resulting from any illness, injury or occurrence as a result of participating in aforementioned program.

Signature of Member: _____ Date: _____

Old Bridge YMCA
1 Mannino Park Drive
Old Bridge, New Jersey
(732) 727-0704
(732) 727-0708-Fax

The YMCA is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take measures in securing your personal information and ensuring that all of this information remains confidential.

YMCA of Western Monmouth County
470 East Freehold Road
Freehold, New Jersey
(732) 462-0464
(732) 462-0255-Fax

PHYSICIAN REFERRAL

Please complete the following:

Patient Name:_____ Date:_____

Address:_____ Age:_____

Phone:_____ Sex:_____

Date of Last Completed Examination:___/____/___

Dear Doctor,

Your patient has requested to participate in an exercise program. The referral is requested for establishing medical clearance to provide initial fitness assessments for beginning an exercise program.

Due to the reasons listed below, we are requesting medical clearance for your patient. Please complete the following form and state to the best of your ability if there are any contraindications or recommendations for participation in the testing procedures or exercise program. This referral is valid only if the client remains on the same medications (type and dose), and is in the same clinical status as on the day of the fitness assessment. The client has signed a statement that it is his/her responsibility to inform the trainer of any changes in their health status. Thank you.

Primary Risk Factors noted on Health History Questionnaire (**for the Trainer only**):

___elevated cholesterol ___cigarette smoking ___high BP/BP meds

___sedentary ___metabolic disease ___CV disease

___age (male > 45/woman > 55) ___family history ___pregnancy

___BMI > 30 ___signs or symptoms of _____

Other information:_____

Based on the information provided and any other information you, the physician, may have concerning your client, your recommendations for exercise is as follows (please check ONE):

I have examined the above applicant and as his/her personal physician recommend the following:

____is NOT CLEARED and cannot exercise at this time.

____is CLEARED and can exercise with no restrictions.

____is CLEARED with the following RESTRICTIONS_____

_____

Please fill in/enclose following information, if it is already available in patient's records:

A. Blood pressure: Systolic/Diastolic (arm) _____/_____ ( ).

Total Serum Cholesterol_____ (HDL –C_____/LDL-C____).

Triglycerides _____ mg/dl.

Glucose_____.

Current Medications

Special Considerations	Medication	Dose	Frequency
1. Musculoskeletal Disorders	_____	_____	_____
2. Asthma	_____	_____	_____
3. Other	_____	_____	_____

Physician Signature: _____

Phone: ( ) _____ Fax: ( ) _____

Name of Physician: (Print) _____

Physician Address: _____