Senior Life Member Health History

Name: _____ Date of Birth: ___/___/___ Phone:_____

Please check any of the following conditions that apply (or have applied) to you. If any ONE of the following conditions is marked, we will require a physician's release before you can begin exercising. Please complete the bottom portion of this form so that we may fax it to your doctor.

___Angina
___Asthma (chronic)
___Arthritis (severe)
___Back pain (chronic)
___Blood embolism
___Cancer
___Congestive heart failure
___Coronary artery disease
___Cramping or pain in legs when walking
___Currently on medication for hypertension
___Diabetes
___Epilepsy
___Female parent had heart disease <65
___Frequent (>1/wk) fainting, light-headed, dizzy
___Fluttering or racing heart
___Heart attack
___Heart murmurs
___Heart valve problems
___High cholesterol (over 240)
___Hypertension (BP >140/90)
___Irregular heart beats
___Joint, bone or muscle pain (chronic)
___Lead a sedentary lifestyle
___Lung disease
___Male parent had heart disease <55
___Neck, jaw or chest pains (not TMJ)
___Peripheral vascular disease
___Rheumatic heart disease
___Shortness of breath/fatigued with daily activity
___Shortness of breath or fatigued at rest
___Stroke
___Swollen ankles or hands at rest
___Recent surgery (Date :_____)
___Thrombolphlebitis

To the best of my knowledge, the above information is true and accurate.

Signature: _____ Date: _____

Attention Dr. _____:
(Your doctor's name here)

Your patient, _____ has joined Senior Life Network and would like to begin participating in our exercise program and/or using exercise equipment. The patient has identified the medical conditions above. Please indicate that you do, or do not give your approval for your patient to begin exercising.

_____ I Approve _____ I do not approve _____The patient needs to be seen in my office

Comments: _____

Physician's Signature: _____

Please return to Senior Life Network by fax to: 580-234-6061