Participant Health History
UnityPoint Health – Meriter Wellness Center

Thank you for enrolling in the Get Fit! Exercise and Healthy Eating Program. Please complete this health history form and submit it to the Wellness Center.
The Wellness Center staff will review your information and contact you with any questions.

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ E-mail: _____

Gender ☐ Male ☐ Female

Physician Information

Primary Care Provider Name: _____

Physician/Clinic Phone (____) _____

Date of Last Physical: ____/____/____

Emergency Contact

In the event of an emergency, please contact:

First Name: _____ Last Name: _____

Phone: _____ (home) _____ (cell) _____ (work)

Medical History

Please list all prescription and non-prescription medication. _____
_____
_____

Are you allergic to or have you had a "bad reaction" to any medication or other substances?

☐No ☐Yes If yes, please list the medication and reaction: _____
_____
_____

Please list all past surgeries, hospitalizations and/or any major injury, and include specifics.

Type of Injury/Surgery/Hospitalization	Year

Please check any statement that is TRUE. If you check any of the following statements, please ask your health care provider to complete a Clearance to Exercise waiver.

I have had:

- ☐ heart attack
- ☐ heart surgery
- ☐ heart failure
- ☐ pacemaker/implantable cardiac defibrillator
- ☐ heart transplantation
- ☐ heart rhythm disturbance
- ☐ heart valve disease or surgery
- ☐ coronary angioplasty or stent
- ☐ cardiac catheterization
- ☐ congenital heart disease

I have experienced or I am currently experiencing:

☐ chest discomfort with exertion ☐ unreasonable breathlessness ☐ dizziness, fainting or blackouts

Please check any statement that is TRUE. If you check two or more of the following statements, please ask your health care provider to complete the Clearance to Exercise waiver.

- ☐ I am a man who is older than 45 years
- ☐ I am a woman who is older than 55 years, and/or I have had a hysterectomy, and/or I am post-menopausal
- ☐ I smoke
- ☐ My blood pressure is over 140/90 and/or I take medication for blood pressure
- ☐ I do not know what my blood pressure is
- ☐ My cholesterol level is over 240 mg/dL
- ☐ I do not know what my cholesterol level is
- ☐ I have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)
- ☐ I am a diabetic and/or I take medicine to control my blood sugar
- ☐ I am physically inactive (i.e., less than 30 minutes of physical activity on at least 3 days per week)
- ☐ I am more than 20 pounds overweight

Acknowledgement

☐ I understand the information provided in this Health History is complete and true.

Full name: _____ Date: ____/____/____

Submit completed form to: UnityPoint Health – Meriter Wellness Center
2501 West Beltline Highway, Suite 207, Madison, WI 53713
Fax: (608) 417-5770