ST. JOHN MEDICAL CENTER
SIEGFRIED Health Club

MEDICAL RECORD NO.	DATE SCHEDULED
HEALTH CLUB NO.	TIME SCHEDULED

Nurse's Notes:

APPLICATION FOR ENROLLMENT

Confidential Record: *Information contained here will not be released except when you have authorized us to do so.*

DATE

LAST NAME	FIRST	MIDDLE	BIRTH DATE	AGE

ADDRESS	HOME PHONE	SEX	MARITAL STATUS

CITY	STATE	ZIP	SOCIAL SECURITY NUMBER

OCCUPATION	EMPLOYER	WORK PHONE

PERSON TO NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP	PHONE NUMBER

DOCTOR	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP	DATE OF LAST PHYSICAL EXAM

MEMBERSHIP CATEGORY DESIRED

☐ **Executive** ☐ Cardiac / Pulmonary Transition: ☐ Land ☐ Water

☐ **Associate** ☐ Social ☐ Other _____

☐ Therapeutic Aquatics ☐ Short Term

FAMILY HISTORY Do you know of any **blood relative** who currently has or has had in the past any of the following?

HIGH BLOOD PRESSURE	☐ Yes	☐ No	Relationship _____	Onset Age ____
STROKE	☐ Yes	☐ No	Relationship _____	Onset Age ____
DIABETES	☐ Yes	☐ No	Relationship _____	Onset Age ____
CHEMICAL DEPENDENCY ALCOHOL / DRUGS (INCLUDING PRESCRIPTION DRUGS)	☐ Yes	☐ No	Relationship _____	Onset Age ____
HEART DISEASE (ANGINA, HEART ATTACK, ANGIOPLASTY, HEART SURGERY)	☐ Yes	☐ No	Relationship _____	Onset Age ____
SUDDEN DEATH	☐ Yes	☐ No	Relationship _____	Onset Age ____

MEDICAL HISTORY (Please check all boxes that apply to you.)

☐ Heart Disease

☐ Angina

☐ Heart Attack Date _____

☐ Heart Surgery - Bypass Date _____

Other Date _____

☐ Angioplasty or Related Procedure Date _____

☐ High Blood Pressure ☐ On Medication

☐ Stroke

☐ Elevated Blood Levels of Cholesterol / Triglycerides

☐ Diabetes

☐ Emphysema

☐ Asthma or Chronic Bronchitis

☐ Peripheral Vascular Disease

☐ Claudication

☐ Phlebitis

☐ Orthopedic Problems

☐ Arthritis

☐ Kidney Disease

☐ Gout

☐ Nervous or Emotional Problems

MEDICAL HISTORY

HAVE YOU EVER HAD:

- ☐ Headaches
- ☐ Fainting
- ☐ Convulsions / Seizures
- ☐ Weakness of an arm or leg
- ☐ Dizzy spells
- ☐ Double vision
- ☐ Stomach or bowel problems

HAVE YOU EVER HAD SHORTNESS OF BREATH:

- ☐ Doing your usual work
- ☐ Which awakens you at night
- ☐ Climbing a flight of stairs
- ☐ Accompanied by wheezing

HAVE YOU EVER EXPERIENCED:

- ☐ Indigestion during exercise
- ☐ A feeling of fullness, tightness, heaviness or pain in your chest
- ☐ Chest discomfort or chest pain radiating to jaws, shoulders, elbows, down either arm or between shoulder blades

DOES THIS SENSATION OCCUR:

- ☐ At rest
- ☐ When walking rapidly or in cold weather
- ☐ With exertion
- ☐ When carrying an object
- ☐ When upset or excited
- ☐ During or after meals
- ☐ When walking up a hill or against the wind
- ☐ During sleep which awakens you

IS THIS DISCOMFORT / PAIN RELIEVED BY:

- ☐ Resting for _____ minutes
- ☐ Nitroglycerin
- ☐ Antacids

HAS A DOCTOR EVER SAID YOU HAD OR HAVE:

- ☐ Heart trouble
- ☐ An abnormal electrocardiogram (ECG / EKG)
- ☐ Heart Murmur Present _____ Past _____

Do you have extra, skipped or rapid heart beats / Palpitations? ☐ Yes ☐ No

Do you experience pain in either leg while walking? ☐ Yes ☐ No

Have you had a stress test in the last year? ☐ Yes ☐ No

PAST OR CURRENT ORTHOPEDIC OR NEUROLOGICAL LIMITATIONS:

☐ Have you ever had surgery or injury to your neck, back, arms or legs? If so, explain _____

☐ Do you have any restrictions or limitations regarding arm or leg movement or your ability to lift? If so, explain _____

☐ Do you have frequent or occasional joint pain? _____

☐ Have you every sustained a neurological injury or illness that has resulted in any physical limitations (stroke, spinal cord injury, head trauma, multiple sclerosis, Parkinson's, etc). If yes, explain:

_____

LIST ANY PRESCRIBED MEDICATIONS YOU ARE NOW TAKING:

LIST ANY OVER-THE-COUNTER MEDICATIONS OR DIETARY SUPPLEMENTS YOU ARE NOW TAKING:

MEDICAL HISTORY

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, PLEASE LIST:

☐ Yes ☐ No

Please give your present height: and weight:

WRITE THE NAMES OF ANY DISEASE YOU HAVE HAD WHICH REQUIRED HOSPITALIZATION:

LIST ANY SERIOUS ILLNESSES YOU HAVE HAD THAT DID NOT REQUIRE HOSPITALIZATION:

SERIOUS INJURIES OR ACCIDENTS:

EXPLAIN ANY OTHER SIGNIFICANT MEDICAL PROBLEMS THAT YOU CONSIDER IMPORTANT FOR US TO KNOW:

FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No Are you on birth control pills? ☐ Yes ☐ No

PERSONAL HABITS

Do you regularly use tobacco products? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Smokeless

How many / day?_____ Age you began: _____ Age you quit? _____

Do you regularly drink alcohol? ☐ Yes ☐ No ☐ 1 oz. per day ☐ 2 oz. per day ☐ 4 oz. per day ☐ Over 6 oz. per day

Beer? ☐ Yes ☐ No ☐ 1 bottle per day ☐ 2 bottles per day ☐ Over 4 bottles per day

At any time in the past were you a heavy drinker? ☐ Yes ☐ No (6 oz. or more of alcohol a day)

Do you usually drink over 6 cups of coffee per day? ☐ Yes ☐ No

Do you drink other caffeinated beverages? ☐ Yes ☐ No How many per day?_____

LIFESTYLE HISTORY

How do you describe the stress in your everyday life? ☐ Slight ☐ Moderate ☐ High

How do you describe the stress in your job? ☐ Slight ☐ Moderate ☐ High

How do you describe your lifestyle? ☐ Sedentary ☐ Active ☐ Heavy labor

Average hours of sleep per night? _____ Average work hours per week? _____

Do you do shift work? _____ What are your hours? _____

EXERCISE HISTORY

In what sports or recreational activities are you active? _____

How long each session? _____ How often? _____

Check your exercise preferences: ☐ Walk ☐ Jog ☐ Run ☐ Swim ☐ Bike ☐ Handball ☐ Racquetball ☐ Tennis

☐ Weight Training ☐ Calisthenics ☐ Aerobic Classes ☐ Other _____

Do you have discomfort, shortness of breath or pain with moderate exercises? _____ Explain _____

_____

What problems have you previously had while exercising? _____

_____

MEMBERSHIP AGREEMENT

All exercise and participation is done at the risk of the member or his / her guest. St. John Medical Center and its management are not liable for personal injury.

By signing this application, the member understands and agrees that he / she waives his / her rights and the rights of his / her heirs, administrators, executors, successors and assigns to all claims arising out ot the use of the premises and the membership including but not limited to personal injury, including bodily injury and death, and all property damage.

By signing this application, I indicate that I have read the above and fully understand and agree to the terms of this application.

_____ _____
SIGNATURE DATE

MEDICAL CLEARANCE / REFERRAL *To be completed by your physician.*

Your patient requests to participate in a supervised exercise program.

_____ is referred by me for health reasons to participate in this program
NAME

☐ without restrictions, ☐ with the following restrictions: _____

_____

_____

_____ _____
PHYSICIAN'S SIGNATURE DATE

St. John Medical Center
Medical Excellence • Compassionate Care
1923 S. Utica Ave. Tulsa, OK 74104-6502

Wellness Programs
1819 E. 19th
Tulsa, OK 74104-5414