

WELCOME TO THE *DUKE HEALTH & FITNESS CENTER!*

MEMBERSHIP APPLICATION

Please complete the following information to help us better serve you

Name: (Last) (First) (MI)

_____/_____/_____
Birthdate Age Gender Daytime Phone Number Evening Phone Number

E-mail address *Please circle preferred method of contact

Mailing/Billing Address City State Zip Code

Primary Occupation Emergency Contact Phone Number

Personal Physician Office Phone/Fax # Date of Last Physical Exam

How did you find out about the Duke Health & Fitness Center?

- | | | |
|--|--|--|
| <input type="checkbox"/> Friend is a member | <input type="checkbox"/> Physician Referral | <input type="checkbox"/> Former Cardiac Rehab Client |
| <input type="checkbox"/> Duke employee | <input type="checkbox"/> Family/Spouse is a member | <input type="checkbox"/> Former Pulmonary Rehab Client |
| <input type="checkbox"/> Web Page | <input type="checkbox"/> Past Member | <input type="checkbox"/> Former Physical Therapy Patient |
| <input type="checkbox"/> Special Promotion, please specify _____ | <input type="checkbox"/> Former Arthritis Client | |

Time you are most likely to exercise:

- 6 AM 8 AM 10 AM NOON 2 PM 5 PM

What is your primary reason for joining the Duke Health & Fitness Center?

Please check any of the following activities you might be interested in:

Group Exercise Classes

- Land Aerobics Water Exercise Classes Mind/Body Classes (yoga, pilates, etc.)
 Arthritis Pool Classes Strength/Flexibility Classes Indoor Cycling

Other

- Cardiovascular Equipment Strength Training Other, please list: _____

Please check any of the following services you might be interested in (some at additional cost):

- Personal Training Massage Therapy Weight Loss Programming
 Nutrition Programming Smoking Cessation Stress Management Programming
 Physical Therapy Arthritis Program Health Psychology/Behavioral Counseling

PLEASE READ CAREFULLY BEFORE SIGNING:

I certify that all statements made on this application are accurate and that my answers to questions on the medical screening questionnaire are complete and true to the best of my knowledge. I understand that any misrepresentation or misinformation in this application/questionnaire could result in the rejection of my application, and could ultimately result in revocation of my membership. I understand that, based on my current symptoms or my medical condition, I may be required to have clearance from a physician, including a baseline medical examination and/or an exercise stress test or screening fitness test before my membership application can be accepted. I understand that additional costs may be incurred based upon services rendered. I authorize my personal physician and any other medical facility to release my medical records for review by appropriate staff at Duke Health & Fitness Center.

Member Signature

_____/_____/_____
Date

HEALTH HISTORY QUESTIONNAIRE

Read carefully and answer all questions. If you answer "Yes" to 2 or more of the questions indicated by "*", you will need a physician's clearance. The form is attached to the application. (In some cases a clearance may be required due to other risk factors not indicated prior to membership appointment).

YES NO

*Are you a male age 45 or older, **OR** are you a female age 55 or older?

*Have you ever regularly smoked cigarettes?

If yes, do you currently smoke cigarettes?

YES Packs/day: _____ Years Smoked: _____

NO Date Quit: _____ Packs/day: _____ Years Smoked: _____

*Do you have, or have you EVER had High Blood Pressure (>140/90)

Are you taking medication for this? Yes No

Do you know your last blood pressure reading? Yes No BP: _____

*Do you have elevated blood sugar or diabetes? If yes, is your diabetes:

well controlled

not very well controlled

not sure

Do you take insulin to control your diabetes? Yes No

Do you take a pill (oral agent) to control your diabetes? Yes No

Is your diabetes controlled by diet alone? Yes No

*Do you have high blood cholesterol (>200 mg/dl) or low HDL cholesterol (< 40 mg/dl)?

Are you taking medication for this? Yes No

Do you know your last cholesterol reading? Yes No

Total: _____ HDL: _____

*Has any member of your immediate family (parents, brothers, sisters) developed heart disease or had a stroke before age 55?

*Do you currently experience chest pain, or a numbness or ache in your left arm, jaw or neck at rest or during physical activity?

Do you lose your balance because of dizziness or do you ever lose consciousness (faint)?

*Do you currently experience shortness of breath when performing daily activities or upon mild exertion, or wake up suddenly with shortness of breath?

Have you ever had an exercise stress test? If yes, what year? _____

YES NO

Are you a post menopausal female NOT currently on hormone replacement therapy?

Do you have a family history of osteoporosis?

Are you currently under a physician's care for an active or chronic medical condition?

Date of last visit: _____ Condition(s): _____

Have your symptoms changed since your last appointment with your primary physician?

Do you know of any reason why you should not do physical activity?

If yes, why? _____

*Has a physician ever told you that you have (or have had) **Heart Disease** (heart attack, surgery, heart murmur, irregular heart beats, angina, heart failure, etc.) OR **Vascular Disease**?

IF **YES**, please check which condition(s) you have (or have had):

YES NO

Heart attack (when? _____)

Coronary Artery Bypass Surgery (when? _____)

Angioplasty (PTCA) or Stent placement (when? _____)

Angina (chest pain/discomfort) If yes, how many episodes in a week? _____

How many SL Nitroglycerin pills do you take per week? _____

Irregular Heart Beats

Heart Failure (when? _____)

Heart Murmur or valvular heart disease (what valve? _____)

Heart Valve Surgery (what valve? _____) (when? _____)

Pacemaker Implant (when? _____)

AICD Implant (when? _____)

Stroke or TIA (when? _____)

Peripheral Vascular Disease

Have you ever been told by a physician that you have any of the following medical conditions:

YES NO

- Thyroid/Kidney/Liver Disease? (Circle) (when?_____)
- Bronchitis/Emphysema/Asthma or other Lung Disease (Circle)
- Ulcer/Colon Disorder (Circle) (when?_____)
- Cancer What type?_____ (when?_____)(current status?_____)
- Seizures (when?_____)
- Chronic or Severe Headaches (when?_____)
- Arthritis What type?_____ Joint(s) affected? _____
- Osteoporosis
- Chronic Orthopedic Problem Specify : _____ (when?_____)
- Major Injury Specify: _____ (when?_____)

If needed, use this space to further explain YES responses:

Please list all major surgery you have had as well as any surgery in the past year (please include dates)

Please list all medications you are currently taking:

Medication Name	Dose	Frequency
<i>example: tenormin</i>	<i>25mg</i>	<i>3 times a day</i>

Allergies: _____

Exercise:

➤ How would you describe your daily activity:

() Sitting most of day () Light activity () On feet 6-8 hrs/day () Manual Labor 6-8 hrs/day

➤ Describe your current exercise routine:

- Aerobic Activities: _____
- Strength/Resistance Activities: _____
- Stretching/Flexibility Activities: _____

Nutrition:

➤ What is your present weight? _____ lbs What is your present height? _____

➤ How long have you maintained your present weight? _____ yrs _____ months

➤ Are you satisfied with your current weight? () Yes () No

➤ Ideally, what would you really like to weigh now? _____ lbs

➤ Do your daily food choices contribute to a healthy lifestyle? () Yes () No

Stress Management:

➤ Overall, how stressful is your life? (Circle One.)

Very Stressful Moderately Stressful Mildly Stressful Not Stressful

➤ In which areas do you experience significant stress? Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Employment-related stress | <input type="checkbox"/> Social/interpersonal concerns |
| <input type="checkbox"/> Family-related stress | <input type="checkbox"/> Financial worries |
| <input type="checkbox"/> Health-related stress | <input type="checkbox"/> Other (Please specify: _____) |

➤ How effective are you with managing your stress? Check the one that best fits you now:

- Very effective (I've got stress under control.)
- Somewhat effective (I've got a handle on stress, but could benefit from more ideas or support in coping with it.)
- Ineffective (I need to learn some new ways to cope with stress.)
- Very ineffective (My stress is overwhelming and I need help coping now.)

Lifestyle Changes:

➤ How interested are you in making lifestyle changes in each of the following areas?

	Very Interested	Moderately Interested	Somewhat interested	Not very interested	Not at all interested
Exercising					
Losing Weight					
Changing my diet					
Managing Stress					
Quitting Smoking					
Improving Relationships					

➤ How likely is it that you will actually make changes in the following areas?

	Very Likely	Moderately Likely	Somewhat Likely	Not very Likely	Not at all Likely
Exercising					
Losing Weight					
Changing my diet					
Managing Stress					
Quitting Smoking					
Improving Relationships					

➤ How much control do you believe you have over the following?

	Complete	Very Much	Some	Not much	None
Exercising					
Losing Weight					
Changing my diet					
Managing Stress					
Quitting Smoking					
Improving Relationships					

Is there anything else you would like to tell us about yourself that would help us to assist you in making positive lifestyle changes at the Duke Health & Fitness Center?
