JEFFERSON HOSPITAL

# WELLNESS CENTER

## APPLICATION

Name: _____ Date of Birth: _____

Address: _____ SS#: _____

Phone: (H)_____ Cell: _____

Employer:_____ Occupation: _____

Personal Physician: _____ Last Physical: _____

Emergency Contact: _____ Phone (____)_____

Your weight: _____ Your height: _____

### Ethnic Origin

_____Asian/Pacific Islander

_____Black

_____ Caucasian /White

_____ Hispanic

_____ Other

### Education Level

_____ Elementary School

_____ High School /GED

_____ Associate's /Technical Degree

_____ Bachelor's Degree

_____ Master's Degree

Have you ever had or been told by a physician that you have any of the following?

If yes when.

_____Heart Attack

_____Stroke

_____Open heart surgery

_____Any form of Heart Disease

_____ Dizziness

_____Skipped Heart Beats

_____Mitral Valve Prolapse

_____High Cholesterol

_____High Blood Pressure _____Rheumatic Fever

_____Pain/Tightness in Chest _____Emphysema or Bronchitis

_____Abdominal Electrocardiogram _____Serious Pneumonia

_____Irregular Heart Rhythm _____Diabetes

_____Shortness of Breath _____Low Blood Sugar

Is there a history of heart disease or high blood pressure in your Immediate family? Yes_____ No_____

Do you suffer from mental stress or insomnia? Yes_____ No _____

Are you on a Special diet? _____ Yes Physician prescribed ____ Yes self prescribed

None _____

Have you sustained an injury to any of the following bone-joint sites? If yes, please date in space provided.

_____ Foot _____Back

_____Ankle _____Neck

_____Knee _____Shoulder

_____Hip _____Other

Would any of the muscle-skeletal conditions above impair or prohibit any form of exercise prescribed for you? ____Yes ____ No

If yes please describe_____

_____
_

Do you smoke at the present time ?

_____Yes _____cigarettes per day

_____Yes _____ cigars per day

_____Yes _____uses of pipe tobacco per day

_____No _____stopped after_____ years of smoking

_____No _____never smoked

Do you consume alcoholic beverages, including mixed drinks, wine, and beer?

_____No I do not drink

_____Yes !-5 drinks per week

_____Yes 6-12 drinks per week

_____Yes 13-25 drinks per week

_____Yes over 26 drinks per week

Please list all medications you are currently taking._____

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Are you aware of any personal limitations medical or otherwise not covered by this questionnaire which would restrict your participation in a planned program of diet and or vigorous physical activity? ____yes _____no

If yes please explain:_____

To the best of my knowledge the information I have supplied above is correct

Signed:_____ Date: _____