

**Oregon Park District**  
**Health and Fitness Information**

\_\_\_\_\_ Date

\_\_\_\_\_ Fitness Center Supervisor

\_\_\_\_\_ Sex: M F  
Last Name First Name Middle Initial Age  
\_\_\_\_\_  
Address City  
\_\_\_\_\_  
State Zip Home phone Work phone

**Health History**

Please read the questions below. If you can answer yes to any of these questions, *you must obtain a doctor's written release prior to use of any equipment located in the Fitness Center.*

**Do you or have you ever had any of the following?**

<u>Heart</u>			<u>Others</u>		
Heart Attack	Yes	No	Diabetes	Yes	No
Heart Disease	Yes	No	Seizures	Yes	No
Stroke	Yes	No	Arthritis	Yes	No
Abnormal EKG	Yes	No	Asthma	Yes	No
High Blood Pressure	Yes	No			
Surgery	Yes	No			
-1 yr. or less					

**If yes, please answer the following (if more than one surgery list all).**

Date of Surgery: \_\_\_\_\_ Reason for surgery: \_\_\_\_\_

Physical Limitations of surgery: \_\_\_\_\_

Do you take any medications? Are you receiving treatments such as chemotherapy?

If yes, please list: \_\_\_\_\_

**Emergency**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preference of Physician or Hospital: \_\_\_\_\_