



CHAMP ASSESSMENT
 Department of
FITNESS & WELLNESS PROGRAMS
MEDICAL HISTORY FORM

Name (First & Last):	Date of Birth:
Email:	Sex assigned at birth:
Phone Number:	Gender identification:
C# (if applicable):	
Membership Type: <input type="checkbox"/> Student <input type="checkbox"/> UM Employee Member <input type="checkbox"/> Alumni Member <input type="checkbox"/> Non-Member	

The CHAMP (basic fitness assessment) may require a physician's consent to participate.

ASSESS YOUR HEALTH BY MARKING ALL TRUE STATEMENTS:

You have experienced:
<input type="checkbox"/> chest pain at rest or with mild exertion <input type="checkbox"/> irregular heart beat or palpitations at rest or with mild exertion <input type="checkbox"/> dizziness, fainting, or blackouts with mild exertion <input type="checkbox"/> ankle swelling <input type="checkbox"/> unusual fatigue or shortness of breath during usual activities
You have had:
<input type="checkbox"/> heart attack <input type="checkbox"/> congenital heart disease <input type="checkbox"/> heart failure <input type="checkbox"/> any heart surgery (inc. catheter) <input type="checkbox"/> cardiac arrhythmia <input type="checkbox"/> kidney disease <input type="checkbox"/> heart murmur <input type="checkbox"/> diabetes (Type I or II) <input type="checkbox"/> hypertension <input type="checkbox"/> PVD (claudication) <input type="checkbox"/> cardiovascular disease <input type="checkbox"/> stroke
<input type="checkbox"/> I perform planned, structured, moderate intensity exercise for at least 30 minutes per session, at least 3 days per week, for at least the last 3 months. <input type="checkbox"/> I DO NOT participate in planned structured exercise as described above.
Check all that apply:
<input type="checkbox"/> you smoke <input type="checkbox"/> your blood pressure is greater than 130/80 <input type="checkbox"/> you take blood pressure medication <input type="checkbox"/> you take medicine to control your blood sugar <input type="checkbox"/> you have high cholesterol or take cholesterol medication <input type="checkbox"/> you are overweight <input type="checkbox"/> you have a close blood relative who had a heart attack before age 55 (father/brother) or age 65 (mother/sister)
<input type="checkbox"/> bone/joint problem: _____ <input type="checkbox"/> low back pain <input type="checkbox"/> unusual muscle fatigue/soreness

Please list (check box if not applicable):

Current medications:	<input type="checkbox"/> not applicable
Recent surgeries:	<input type="checkbox"/> not applicable
Current injuries:	<input type="checkbox"/> not applicable
Physical limitations:	<input type="checkbox"/> not applicable

I UNDERSTAND THAT ALL APPOINTMENT CANCELLATIONS MUST OCCUR 24 BUSINESS HOURS IN ADVANCE. FAILURE TO DO SO WILL RESULT IN A \$10.00 ADMINISTRATIVE FEE. _____ (MUST INITIAL HERE)

WAIVER AND SIGNATURES

I answered the questions accurately and correctly. I understand that my medical history is an important factor in the development of my exercise and fitness program. Medicine is not an exact science and no guarantees can be made as to the safety of exercise activities. I understand that known, unknown, or undisclosed medical or physical conditions may result in injury. I knowingly and willingly assume all risks, and I hereby release The Department of Wellness and Recreation, The University of Miami, its agents and employees from any and all liability, damage, or loss arising of/or resulting from my participation in this program or service, especially including any negligence of the University's part.

Print Name

Participants Signature

Date

Witness Signature (Mandatory if under 18 years old)

Date

For Staff Use Only:

Date received: _____ MD consent required: Y or N Consent requested: _____ Consent received: _____

Appointment date: _____ Staff assignment: _____