Click here to Submit

UNIVERSITY OF MIAMI
PATTI & ALLAN HERBERT
WELLNESS CENTER

FITNESS & WELLNESS PROGRAMS
MEDICAL HISTORY FORM

Name (First & Last): test	**Date of Birth:**
Email: **Phone Number:**	**Sex assigned at birth:**
C# (if applicable):	**Gender identification:**
Membership Type: ☐ Student ☐ UM Employee Member ☐ Alumni Member ☐ Non-Member	

Please indicate which service(s) you are requesting. Some programs/services may require a physician's consent to participate.

Fitness Programs:

- ☐ **Personal Training (includes assessment)**
- ☐ **Supervised Exercise Program (includes assessment)**
- ☐ **Private Pilates**
- ☐ **LIFE Senior Fitness Program**

Fitness Lab Testing:

- ☐ **VO2 Max Testing**
- ☐ **General Fitness Assessment (CHAMP)**
- ☐ **BodPod (Body Composition)**
- ☐ **Resting Metabolic Rate**
- ☐ **Nutrition Education**

ASSESS YOUR HEALTH BY MARKING ALL TRUE STATEMENTS:

You have experienced:

- ☐ chest pain at rest or with mild exertion
- ☐ dizziness, fainting, or blackouts with mild exertion
- ☐ unusual fatigue or shortness of breath during usual activities
- ☐ irregular heart beat or palpitations at rest or with mild exertion
- ☐ ankle swelling

You have had:

- ☐ heart attack
- ☐ **any** heart surgery (inc. catheter)
- ☐ heart murmur
- ☐ PVD (claudication)
- ☐ congenital heart disease
- ☐ cardiac arrhythmia
- ☐ diabetes (Type I or II)
- ☐ cardiovascular disease
- ☐ heart failure
- ☐ kidney disease
- ☐ hypertension
- ☐ stroke

☐ 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.

☐ I **DO NOT** participate in planned structured exercise as described above.

Check all that apply:

- ☐ you smoke
- ☐ you take blood pressure medication
- ☐ you have high cholesterol or take cholesterol medication
- ☐ you have a close blood relative who had a heart attack before age 55 (father/brother) or age 65 (mother/sister)
- ☐ your blood pressure is greater than 130/80
- ☐ you take medicine to control your blood sugar
- ☐ you are overweight

- ☐ bone/joint problem: _____
- ☐ low back pain
- ☐ unusual muscle fatigue/soreness

Please list (check box if not applicable):

Current medications:	☐ not applicable
Recent surgeries:	☐ not applicable
Current injuries:	☐ not applicable
Physical limitations:	☐ 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: _____