



Fitness Services Application

Dear applicant,

Thank you for your interest in the Flynn Recreation Complex Fitness Services. The first step in designing an effective program of fitness is finding out more about you. With the help of a health and medical history questionnaire we will be able to develop the safest, most effective program possible. At the time of your first appointment you MUST HAVE the Health and Medical History Questionnaire located on the following pages completed. Thank you again for your interest in our fitness services.

Sincerely,
The Fitness Staff

Health and Medical History Questionnaire

CONFIDENTIALITY

The information obtained from this questionnaire as well as from your fitness evaluation will be treated as privileged and confidential. It will not be revealed to anyone without your expressed written consent. Any and all Flynn Recreation Complex staff with access to your information have signed a confidentiality agreement and agreed to the Flynn Recreation Complex Confidentiality of Medical Information Statement (see last page)

Name: _____

Date: _____

Address(Home/Campus): _____

Age: _____ Date of Birth: _____

Sex: _____ Height: _____ Weight: _____

*Race/Origin: _____

Home/campus phone: () _____

E-mail address: _____

Mobile: () _____

Name of personal physician: _____

Telephone: () _____

*Racial/ethnicity questions are optional and are used for the purpose of measuring body fat percentage using formulas based on population norms for specific origin.

1. If you have ever experienced any of the following conditions, please check the box next to that item.

- Do you have any immediate family members who have had a heart attack, coronary revascularization, or sudden death before 55 years of age in father or brother, or before 65 years of age in mother or sister?
- Do you currently smoke cigarettes or have you quit within the previous 6 months ?
- Have you had systolic blood pressure greater than 140 mmHg or diastolic blood pressure greater than 90 confirmed by measurements on at least two separate occasions, or are you on an antihypertensive medication?
- Do you have LDL ("bad" cholesterol) greater than 130 mg/dL, or HDL ("good" cholesterol) less than 40 mg/dL, or a total serum cholesterol greater than 200, or are you on any lipid- lowering medication?
- Do you have fasting blood glucose greater or equal to 100 mg/dL confirmed by measurements on at least two separate occasions?
- Do you have a Body Mass Index of greater than 30 kg/m, or are you over 20% overweight or do you have a waist girth greater than 102 cm for men and 88 cm for women?
- Do you have a sedentary lifestyle (do not participate in a regular exercise program or do not accumulate at least 30 minutes of moderate physical activity on most days of the week.)?

2. Please check any of the following that apply

- Do you have any personal history of heart disease (coronary or atherosclerotic disease)?
- Any personal history of diabetes or other metabolic disease (thyroid,renal,liver)?
- Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?
- Have you experienced pain or discomfort in your chest, neck, jaw, arms, or other areas apparently due to blood flow deficiency?
- Any unaccustomed shortness of breath (at rest or with mild exertion)?
- Have you had any problems with dizziness or fainting?
- Do you have difficulty breathing while standing or sudden breathing problems at night?
- Have you experienced unpleasant awareness of the forceful or rapid throbbing or fluttering of the heart?
- Do you suffer from ankle edema (swelling of the ankles)?
- Have you experienced severe pain in leg muscles during walking?
- Do you have a known heart murmur?

****Important: If you checked one or more boxes in this section you must contact the Senior Fitness Trainer before coming to your scheduled fitness evaluation.***

3. Medical History – Detail

Please check all conditions or diagnoses that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal EKG? | <input type="checkbox"/> Limited Range of Motion? | <input type="checkbox"/> Stroke? |
| <input type="checkbox"/> Abnormal Chest X-Ray? | <input type="checkbox"/> Arthritis? | <input type="checkbox"/> Do You Suffer from Epilepsy or Seizures? |
| <input type="checkbox"/> Rheumatic Fever? | <input type="checkbox"/> Bursitis? | <input type="checkbox"/> Chronic Headaches or Migraines? |
| <input type="checkbox"/> Low Blood Pressure? | <input type="checkbox"/> Swollen or Painful Joints? | <input type="checkbox"/> Persistent Fatigue? |
| <input type="checkbox"/> Asthma? | <input type="checkbox"/> Foot Problems? | <input type="checkbox"/> Stomach Problems? |
| <input type="checkbox"/> Bronchitis? | <input type="checkbox"/> Knee Problems? | <input type="checkbox"/> Hernia? |
| <input type="checkbox"/> Emphysema? | <input type="checkbox"/> Back Problems? | <input type="checkbox"/> Anemia? |
| <input type="checkbox"/> Other Lung Problems? | <input type="checkbox"/> Shoulder Problems? | <input type="checkbox"/> Are You Pregnant? |
| | <input type="checkbox"/> Recently Broken Bones? | |

Has a doctor imposed any activity restrictions? If so, please describe:

Family History

Have your mother, father, or siblings suffered from (please select all that apply):

| | |
|--|--|
| <input type="checkbox"/> Heart attack or surgery prior to age 55. | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stroke prior to age 50. | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Congenital heart disease or left ventricular hypertrophy. | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Leukemia or cancer prior to age 60. |

Medications

Please Select Any Medications You Are Currently Using:

| | |
|---|---|
| <input type="checkbox"/> Diuretics | <input type="checkbox"/> Other Cardiovascular |
| <input type="checkbox"/> Beta Blockers | <input type="checkbox"/> NSAIDS/Anti-inflammatory (Motrin, Advil) |
| <input type="checkbox"/> Vasodilators | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Alpha Blockers | <input type="checkbox"/> Diabetes/Insulin |
| <input type="checkbox"/> Calcium Channel Blockers | <input type="checkbox"/> Other Drugs (record below). |

Please list the specific medications that you currently take:

Lifestyle

Are you a cigarette smoker? If so, how many per day?

Previously a cigarette smoker? If so, when did you quit?

How many years have you smoked or did you smoke before quitting?

Do you/did you smoke (Circle one): Cigarettes Cigars Pipe

Please Rate Your Daily Stress Levels (select one):

| | | | | |
|------------------------------|-----------------------------------|---|--|---|
| <input type="checkbox"/> Low | <input type="checkbox"/> Moderate | <input type="checkbox"/> High but I enjoy the challenge | <input type="checkbox"/> High: sometimes difficult to handle | <input type="checkbox"/> High: often difficult to handle. |
|------------------------------|-----------------------------------|---|--|---|

Do you drink alcoholic beverages?

How many alcohol beverages do you consume per week: _____ (see Alcohol table below)

Alcohol Table

| Type of Drink | Units |
|-------------------------------------|-------|
| ½ pint of beer | 1 |
| 1 glass of wine | 1 |
| 1 shot of spirits (Gin, Vodka etc.) | 1 |
| 1 can of beer | 1.5 |
| 1 bottle of strong lager | 2.5 |
| 1 can of strong lager | 4 |

Dietary Habits. Please Select All That Apply.

| | |
|--|---|
| <input type="checkbox"/> I seldom consume red or high-fat meats. | <input type="checkbox"/> I eat at least ___ servings of fruits per day. I eat at least ___ servings of vegetables per day. |
| <input type="checkbox"/> I pursue a low-fat diet. | <input type="checkbox"/> I almost always eat something for breakfast. |
| <input type="checkbox"/> My diet includes many high-fiber foods. | <input type="checkbox"/> I rarely eat high-sugar or high-fat desserts. |

Other

Please Indicate Any Other Medical Conditions or Activity Restrictions That You May Have. It is important that this information be as accurate and complete as possible

Is any of this information critical to understanding your readiness for exercise? Are there any other restrictions on activity that we should know about?

5. Please describe your current exercise program using the boxes below. (Aerobic Activity = cycling, jogging, walking, etc. Resistance Training Activity = toning classes, Nautilus equipment, free weights, etc.)

| Aerobic Activity | Sessions Per Week | Minutes Per Session | Level of Intensity (Low, Medium, High) | Date You Began This Activity |
|-------------------------------------|--------------------------|----------------------------|---|-------------------------------------|
| | | | | |
| | | | | |
| Resistance Training Activity | Sessions Per Week | Minutes Per Session | Sets And Repetitions | Date You Began This Activity |
| | | | | |

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

I have answered the questions in this health and medical history questionnaire to the best of my ability, and I attest that the information I have provided is truthful to my knowledge. I have understood all the questions asked of me, and I have been given the opportunity to have any parts of this questionnaire I do not understand explained to me and/or have any of my concerns clarified to my satisfaction. I further understand that thorough and honest responses to these questions are essential to my safety and for providing the Flynn Recreation Complex Fitness Center Staff with the necessary information in order to provide me with a safe, effective health and fitness program.

Signature

Date

Instructor notes:

Participant's availability for exercise program:

Intended plan to achieve fitness goals:

Informed Consent Form

Assessment Objectives: The assessment you are about to undergo is designed to give a reasonable measure of your current level of fitness, and will include the following (Check where appropriate):

- Aerobic Capacity
- Body Composition
- Lung Function
- Flexibility
- Muscular Strength
- Muscular Endurance

Explanation of Procedures: The tests will be explained to you by the member of staff and they will be pleased to answer any questions you may have. Certain pieces of specialized equipment will be used to perform the assessment, and you can stop the test at any point if you feel uncomfortable or unwell.

Potential Risks: Because of the nature of the assessment, a level of exertion is required. This exertion will cause temporary changes which will increase the heart rate and raise the blood pressure. This may place participants with cardiovascular or other disease – whether diagnosed or undiagnosed – at significant risk for adverse events or even death. In addition, as with all vigorous physical activity, there exists a risk musculoskeletal injury. Please note that while these outcomes are rare, it is quite common for participants to experience some stiffness in the muscles in the next few days after testing. Our staff are trained to perform assessments and first aid and will respond quickly to any problems.

Potential Benefits: Your assessment results will help to determine your present level of fitness, and highlight any areas of specific need. This will be particularly useful when designing an exercise program that will be personalized, safe, and effective.

Consent: I have read the information on this page and I understand it. Any questions concerning the information and procedures have been answered to my satisfaction. I also understand that I am free to stop the assessment at any time and seek professional medical advice or opinion.

Any information derived from the assessment is confidential and will not be disclosed without my permission to anyone other than my Doctor or the staff of this facility. However, I agree that information from the assessment not attributable to me may be used for research purposes and stored on an electronic database.

Participant Signature: _____

Date: _____



BOSTON COLLEGE

Flynn Recreation Complex

CONFIDENTIALITY OF MEDICAL INFORMATION STATEMENT

Policy:

The personal privacy and confidentiality of member information will be maintained and respected by all employees of the Flynn Recreation Complex.

Procedure & Responsibilities:

1. Member records may be accessed only by those individuals who are members of the Flynn Recreation Complex Fitness Staff and are either directly providing member services or performing clerical duties.
2. Written permission from the member must be obtained prior to releasing information to any individual not mentioned in #1.
3. All Plex employees will be required to sign a confidentiality statement.
4. All information about members will be held in strict confidence. Any violation of this trust will be considered a serious offense and will result in disciplinary action &/or termination.
5. The Assistant Director, Fitness and Facility Operations is responsible for communicating this policy to all of his/her employees.