Georgia State University
The Fitness Center
Recreational Services

Georgia State University | RECREATIONAL SERVICES
DIVISION OF STUDENT AFFAIRS

Client Information

All information given is confidential. The information will enable us to work with you safely and effectively.

Name _____ Date _____

Panther #_____ Campus ID _____ Phone _____

Affiliation ☐Student ☐Faculty ☐Staff ☐Other _____

Address_____

City/State _____ Zip Code _____

Email _____ Occupation_____

Date of Birth _____ Gender _____ Height _____ Weight _____ Race _____

Were you referred to us by the GSU Health Clinic? ☐ Yes ☐ No

If yes, state reason for referral. Please be specific! _____

_____

_____

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Staff Use Only

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Resting blood pressure: _____ Resting heart rate: _____

Do any medications affect BP or HR? ☐Yes ☐No If yes, which? _____

_____

Is a medical clearance necessary? ☐No ☐Yes If yes, date received: _____

Date: _____ Fitness Center Staff Name: _____

Comments: _____

_____

Medical Health History

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I. Current Activity

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In the past 3 months, have you maintained structured physical activity for at least 30 minutes at a moderate intensity at least 3 days a week?

☐ Yes ☐ No

If you answered yes, please describe the type of structured physical activity performed.

_____

If you answered no, please describe any barriers preventing you to do so.

_____

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II. Signs and Symptoms

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Have you ever experienced any of the following?

1. Pain, discomfort, tightness or numbness in the chest, neck, jaw or arms. ☐ Yes ☐ No

2. Shortness of breath at rest or with mild exertion. ☐ Yes ☐ No

3. Dizziness or fainting. ☐ Yes ☐ No

4. Difficult, labored or painful breathing during the day or at night. ☐ Yes ☐ No

5. Ankle swelling. ☐ Yes ☐ No

6. Rapid pulse or heart rate. ☐ Yes ☐ No

7. Intermittent cramping. ☐ Yes ☐ No

8. Known heart murmur. ☐ Yes ☐ No

9. Unusual shortness of breath or fatigue with usual activities. ☐ Yes ☐ No

If you answered <u>yes</u> to any of the above:

How often do you experience the symptom? _____

Have you ever discussed the symptom with a doctor? _____

Explain the symptom in more detail: _____

_____

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III. Medical Diagnoses

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Have you ever had any of the following? Circle all that apply:

heart attack	angioplasty	heart surgery	congenital heart disease
lung disease	asthma	heart failure	pacemaker/ICD
diabetes	heart transplant	heart valve disease	cardiac catheterization
anemia	phlebitis	emboli	stroke
osteoporosis	cancer	emotional disorders	eating disorders
heart clicks	angina	hypertension	coronary artery disease

If any of the above are circled, please give details / explain: _____

_____

Any medical diagnosis or special circumstances not listed above? _____

_____

If you have experienced none of the above, please initial indicating you have reviewed this section: _____

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IV. General

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1. Are you pregnant? ☐ Yes ☐ No

2. Do you have arthritis or any bone or joint problem? ☐ Yes ☐ No

If yes, please explain: _____

_____

3. Are you taking any medication, vitamins or supplements? ☐ Yes ☐ No

If yes, name them, the dosage, drug purpose and whether it is prescribed (Rx) or over-the counter (OTC):

_____

_____

_____

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My signature certifies that all of the above is true, to the best of my knowledge. I agree to update any changes to this given information as they occur.

Signature: _____ Date: _____

Revised 6/2017