

**Advanced Cardiac Fitness Program
Health History**

I. General Information

Name: _____ SSN: _____ - _____ - _____

Address: _____ Home Phone: _____ - _____ - _____

City, State, Zip: _____ Cell Phone: _____ - _____ - _____

Date of Birth: ___ / ___ / ___

Gender: _____ Height: _____ Weight: _____

Please list physicians from whom you are receiving care:

NAME	PHONE
1. _____	_____
2. _____	_____
3. _____	_____

Allergies:

II. Signs and Symptoms

Have you ever experienced any of the following?

(please circle yes or no)

- | | | |
|-----|----|---|
| yes | no | 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. |

If you answered yes to any of the above:

Frequency of symptom(s):

Have symptom(s) been discussed with a doctor? Yes No

Provide additional details of doctor's instructions:

III. Major Risk Factors

- yes no 1. Do you have a body mass index ≥ 30 or a waist girth > 39.4 inches?
- yes no 2. Have you had a fasting glucose of 110 mg/dl confirmed by measurements on at least 2 separate occasions?
- yes no 3. Has your father or brother experienced a heart attack before the age of 55? Or has your mother or sister experienced a heart attack before the age of 65?
- yes no 4. Do you smoke? Quit Date: _____
- yes no 5. Has your doctor ever told you that you have high blood pressure?
- yes no 6. Do you have high cholesterol?
Total cholesterol: _____ **HDL:** _____ **Date tested:** _____
- yes no 7. Do you have a sedentary lifestyle? (Sitting most of the day in your job with no regular physical activity)

IV. Medical Diagnoses

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

- | | | | |
|-------------------------|---------------------|---------------|-----------------|
| heart attack
disease | angioplasty | heart surgery | coronary artery |
| angina | hypertension | heart murmur | asthma |
| emphysema | bronchitis | stroke | anemia |
| cancer | phlebitis | emboli | osteoporosis |
| eating disorders | emotional disorders | | |

Any special problems not listed above:

If you circled any above, please provide detailed explanation:

V. General

yes no 1. Do you have arthritis or any bone or joint problem?

If yes, please explain:

yes no 2. Do you currently exercise?

If yes, how long have you been exercising?

Type & frequency of exercise:

yes no 3. Are you taking any medications, vitamins or supplements?

Please provide name of medication/supplement, dosage and how often you take the medication/supplement:

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

yes no 4. Has your doctor ever said that you have a heart condition and you should only do physical activity recommended by a doctor?

yes no 5. Do you feel pain in your chest when you do physical activity?

yes no 6. In the past month, have you had chest pain when you were not doing physical activity?

yes no 7. Do you lose your balance because of dizziness or do you ever lose consciousness?

yes no 8. Is your doctor currently prescribing drugs for your blood pressure or heart condition?

VI. Emergency Contact Information

Please provide at least 2 emergency contacts.

NAME
RELATIONSHIP

PHONE

1. _____ -_____-_____

2. _____ -_____-_____

My signature certifies that all of the above is true, to the best of my knowledge.

Print Name: _____

Signature: _____

Date:___/___/___



**ADVANCED CARDIAC FITNESS PROGRAM PARTICIPATION
ACKNOWLEDGEMENT**

I understand that my participation in any of the Preventive Cardiology exercise program(s) (non-medically supervised) in the Preventive Cardiology Department of Saint Joseph's Hospital of Atlanta will not be under a physician's supervision.

I understand that my participation in the Program will enable me to use all available facilities during specified hours of operation and attend any or all of the education classes offered to patients.

I understand that my participation in the Program requires my completion of this Agreement and a Health History, my physician's submission of a Physician Referral and a monthly payment of Fifty Dollars (\$50.00) to be paid monthly and a one time Fifty Dollars (\$50.00) enrollment fee.

I further understand that as a participant in the Program, I may obtain a Fitness Assessment that will enable an Exercise Specialist to create an individualized exercise program for me for a fee of Fifty Dollars (\$50.00).

Waiver of Liability and Release

I understand and agree that my activities, exercise, use of equipment and facilities shall be undertaken at my sole risk and that the Hospital and its affiliated corporate entities shall not be liable for any claims, demands, injuries, damages, actions or causes of action to me or my property arising out of or connected with my use of any of the facilities and/or services of this Program.

I further expressly release, indemnify and hold harmless the Hospital, its affiliated corporate entities, the Hospital's employees and agents, from any and all liability whatsoever. The Hospital shall not be responsible or liable for any loss or damage to my property in or about the Preventive Cardiology Department.

State of Health

I understand that the Hospital has encouraged me to have a physical examination by a physician prior to starting any program of strenuous activity and that to participate in this program, I must have a physician referral, provide a health history, and sign this acknowledgement.

I understand that if, during my participation in the exercise program, the Hospital believes I have or may have a problem that, in the reasonable judgment of a nurse or exercise specialist in the Preventive Cardiology Program, appears to require physician follow-up, my referring physician will be notified.

I agree to abide by participant guidelines as they may be provided to me regarding proper use of facilities and services.

Signature: _____ **Date:** _____

Printed Name: _____



PHASE III/ADVANCED CARDIAC FITNESS PROGRAM

Debit Authorization

I authorize the Saint Joseph's Hospital of Atlanta to effect payment for monthly dues by charging my credit/bank card. This authorization is to remain in full effect until one of the following occurs:

- The Saint Joseph's Hospital of Atlanta. receives notice from me of the cancellation of this bank or credit card account,
- The Saint Joseph's Hospital of Atlanta sends me written notice of the termination of this agreement,
- My bank notifies me, or the Saint Joseph's Hospital of Atlanta of their termination of this agreement, or
- The Saint Joseph's Hospital of Atlanta receives notification from me of my desire to discontinue the cardiac rehabilitation program.

I understand that I am responsible for notifying Cardiac Rehabilitation of any changes that occur affecting my bank/ credit card. If I receive a new credit/bank card expiration date or a new credit card number, if I am notified of the cancellation of my credit card, and/or if I close the account provided to you for applying the debit, I will notify the Preventive Cardiology office immediately at 678-843-7633.

I understand that I am responsible for all fees incurred for services received during my participation in the Saint Joseph's Hospital of Atlanta Preventive Cardiology. Should my credit card decline the charge or if my bank returns a notice of Nonsufficient Funds (NSF), I understand that I am immediately responsible for payment of the monthly fees by check.

Print First and Last Name

Comments: Current Credit/Bank Information on file will be used. (Initial)_____

Signature

X _____ Date _____

For Preventive Cardiology Office Use Only

Membership Type Preventive Cardiology

Credit Card Information Account # _____ Exp. Date _____

CARDIAC HEALTH & REHABILITATION

INFORMATION SHEET, PHASE III/Advanced Cardiac Fitness

2010

LAST NAME:	FIRST NAME & MIDDLE INITIAL
DATE OF BIRTH:	Last 4 digits of SS #:
STREET ADDRESS:	CITY, STATE, ZIP:
HOME PHONE:	WORK PHONE:
SPOUSE' FIRST NAME:	SPOUSE'S WORK PHONE:
PRIMARY CARE PHYSICIAN:	PCP PHONE:

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT & RELATIONSHIP:	EMERGENCY PHONE NUMBER:
CARDIOLOGIST NAME:	CARDIOLOGIST PHONE NUMBER: