



DATE: _____

Personal Information:

Name: _____
Last (Maiden) First MI

Address: _____
Street City State Zip

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____
Home Cell Business

E-mail address: _____

Sex: Male Female D.O.B.: _____ / _____ / _____ Age: _____

Emergency contact: _____ Relationship: _____

Emergency phone: _____

Physician's Name: _____ Specialty: _____

Physician Phone #: (____) _____ - _____ Physician Fax #: (____) _____ - _____

Address: _____
Street City State Zip

Medical History:

Please check all that apply and explain in the space provided below:

- | | |
|--|--|
| <input type="checkbox"/> Chronic asthma/exercise induced asthma | <input type="checkbox"/> Kidney or urinary tract disease |
| <input type="checkbox"/> Blackouts/fainting spells/dizziness | <input type="checkbox"/> Major surgery or hospitalizations |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Neurological (ex. Parkinson's disease, etc) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Orthopedic problems or joint replacement |
| <input type="checkbox"/> Chest pain (angina) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Coronary bypass/cardiac surgery | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Disc problems | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Peripheral vascular disease/leg cramps |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Epilepsy/seizures/convulsions | <input type="checkbox"/> Pregnant (currently) |
| <input type="checkbox"/> Heart attack/heart disease | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Heart murmur/ heart valve disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Heart palpitations/extra or skipped beats | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High blood pressure | |

Please indicate year of diagnosis or treatment (continue on other side if you need more room)

Specialist's Contact Information

If you have checked any of the medical conditions listed in the Medical History section, please fill in the physician's name and contact information below.

Physician's Name: _____ Specialty: _____

Office Phone #: (____) _____ - _____ Office Fax #: (____) _____ - _____

Physician's Name: _____ Specialty: _____

Office Phone #: (____) _____ - _____ Office Fax #: (____) _____ - _____

Physician's Name: _____ Specialty: _____

Office Phone #: (____) _____ - _____ Office Fax #: (____) _____ - _____

Medications

List all current medications, including dosage and frequency. Include over-the-counter, self-prescribed, and prescription medications.

Medication	Condition	Dosage	Frequency	Year Begun

Please tell us:

The best method of contact (check all applicable): _____ Home _____ Work

_____ Cell _____ E-mail

The best time to contact (circle all applicable): Mornings Daytime Evening Weekends

Best days and times available for appointments: _____

Please be aware that a Physician's referral form is required for participation in the Harry & Jeanette Weinberg Foundation Fitness Center.

... at the Edward A. Myerberg Senior Center

3101 Fallstaff Road Baltimore, MD 21209

Phone: 410-358-6856 Fax: 410-358-1816