

DOMINO'S FARMS FITNESS CENTER

MEMBERSHIP FORM

NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE (HOME) _____ (WORK) _____

EMAIL _____

DATE OF BIRTH _____ MALE _____ FEMALE _____

EMPLOYER _____

DEPARTMENT _____

EMERGENCY CONTACT _____

EMERGENCY PHONE (H) _____ (W) _____

I AM INTERESTED IN RECEIVING THE FITNESS CENTER'S MONTHLY NEWSLETTER VIA EMAIL

I AM INTERESTED IN RECEIVING INFORMATION REGARDING THE AEROBICS PROGRAM VIA EMAIL

CORONARY RISK PROFILE

Y N ARE YOU TAKING MEDICATION FOR HIGH BLOOD PRESSURE? IF YES, WHAT? _____

Y N ARE YOU CURRENTLY TAKING MEDICATION FOR HIGH CHOLESTEROL? IF YES, WHAT? _____

Y N DO YOU CURRENTLY SMOKE?

Y N DO YOU HAVE DIABETES? Y N DO YOU TAKE INSULIN?

Y N HAVE YOU OR ANYONE IN YOUR IMMEDIATE FAMILY (BEFORE AGE 55) HAD A HEART ATTACK, HEART SURGERY OR ANGINA? IF YES, DESCRIBE: _____

CARDIOPULMONARY / METABOLIC SYMPTOMS

Y N HAS A PHYSICIAN EVER NOTIFIED YOU OF A HEART OR LUNG PROBLEM? IF YES, DESCRIBE: _____

Y N DO YOU EVER EXPERIENCE SHORTNESS OF BREATH WITH VERY LIGHT EXERTION?

Y N DO YOU EVER HAVE PRESSURE OR DISCOMFORT IN YOUR CHEST DURING EXERTION?

Y N DO YOU EVER FEEL "SKIPS" OR PALPITATIONS IN YOUR CHEST?

Y N DO YOU EVER EXPERIENCE DIZZY SPELLS OR FEELINGS OF FAINTNESS?

ORTHOPEDIC HISTORY

Y N HAVE YOU EVER HAD A SERIOUS BACK INJURY OR EXPERIENCED CHRONIC BACK PAIN/DISCOMFORT?

Y N HAVE YOU EVER HAD A SERIOUS INJURY, OR CHRONIC PAIN WITH YOUR JOINTS (BACK, KNEE, SHOULDER, ELBOW, NECK, ETC.) OR ARTHRITIS? IF YES, DESCRIBE: _____

MEDICAL HISTORY

Y N DO YOU HAVE ANY OTHER MEDICAL CONDITIONS OR HEALTH ISSUES THAT WE SHOULD BE AWARE OF? IF YES, DESCRIBE: _____

MEDICATIONS

LIST ANY MEDICATIONS YOU TAKE ON A REGULAR BASIS: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, PLEASE LIST: _____

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For office use only:

Member #: _____

Exp Date _____