

# 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. (IF 1 OR MORE ARE CIRCLED YES, YOU MUST HAVE A DOCTORS NOTE.)**

- Y N DO YOU CURRENTLY HAVE HIGH BLOOD PRESSURE (>140OR>90)?  
Y N ARE YOU TAKING MEDICATION FOR HIGH BLOOD PRESSURE? IF YES, WHAT? \_\_\_\_\_  
Y N DO YOU CURRENTLY HAVE HIGH CHOLESTEROL (240 OR HIGHER)?  
Y N ARE YOU CURRENTLY TAKING MEDICATION FOR CHOLESTEROL? IF YES, WHAT? \_\_\_\_\_  
Y N DO YOU CURRENTLY SMOKE  
Y N ARE YOU A DIABETIC? DO YOU TAKE INSULIN? Y N  
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 (\*IF 2 MORE MORE ARE CIRCLED YES, YOU MUST HAVE A DRS NOTE)**

- Y N HAS A PHYSICIAN EVER TOLD YOU THAT YOU HAVE A HEART OR LUNG PROBLEM? IF YES, DESCRIBE:  
Y N DO YOU GET UNUSUALLY SHORT OF BREATH WITH VERY LIGHT EXERTION?  
Y N DO YOU EVER HAVE PRESSURE OR DISCOMFORT IN THE CHEST AREA DURING EXERTION?  
Y N DO YOU EVER FEEL "SKIPS" OR PALPITATIONS IN YOUR CHEST?  
Y N DO YOU EVER HAVE DIZZY SPELLS OR FEELINGS OF FAINTNESS?  
Y N DO YOU REGULARLY GET MOWER LEG PAIN DURING WALKING?

**ORTHOPEDIC HISTORY**

- Y N HAVE YOU EVER HAD A SERIOUS BACK PROBLEM OR HAVE FREQUENT BACK PAIN?  
Y N HAVE YOU EVER HAD AN INJURY, PROBLEMS WITH YOUR JOINTS (BACK, KNEE, SHOULDER, ELBOW, NECK, ECT.) OR ARTHRITIS? IF YES, DESCRIBE: \_\_\_\_\_

**MEDICAL HISTORY**

- Y N DO YOU HAVE ANY MEDICAL CONDITIONS OR HEALTH PROBLEMS, WHICH MAY AFFECT YOUR EXERCISE PROGRAM THAT WE SHOULD BE AWARE OF? IF YES, DESCRIBE: \_\_\_\_\_

**MEDICATIONS**

LIST ANY MEDICATIONS YOU TAKE ON A REGULAR BASIS: \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATION? IF SO, PLEASE STATE: \_\_\_\_\_

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For office use only:

Member #: \_\_\_\_\_

Exp Date \_\_\_\_\_