

Gypsy Aquatics Health History Form

We enjoy having you use our facility, but if you were to have a problem while here with us, we would want to be as informed and helpful as possible. Please complete this form fully and accurately so we can be. Thanks so much.

Participant Information:

Name: _____ DOB : ___/___/___ Sex: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Ph: _____ Cell/Work#: _____

Email address (optional): _____

Emergency Information:

Contact Name: _____ Relationship: _____

Home #: _____ Work: _____ Cell: _____

Primary Physician:

Name: _____ Phone #: _____

Health History:

Please read and answer the following questions. This form will be kept confidential.

YES NO

- 1. Do you have a heart condition?
- 2. Have you ever experienced a stroke?
- 3. Do you have epilepsy?
- 4. Are you pregnant?
- 5. Do you have diabetes?
- 6. Do you have a chronic lung condition (asthma, bronchitis, emphysema)?
- 7. Do you ever lose consciousness or control of your balance due to chronic dizziness?
- 8. In the past year, have you had chest pain?
- 9. Are you currently being treated for a bone or joint problem that affects your mobility?
- 10. Do you have high blood pressure or high cholesterol?
- 11. Are you currently taking medicine to control your blood pressure?
- 12. Do you have a family history of heart attacks or strokes before age 55?
- 13. Have you been hospitalized recently?
- 14. Do you smoke?
- 15. Are you currently taking any medications? Please list below:
- 16. Do you have any drug allergies? Please identify: _____

If you checked yes on any of the above, or if there is anything else we should know, please explain:
