

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

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have a heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever experienced a stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you have epilepsy? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you have any problems with your kidneys or renal system? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you have a chronic lung condition (asthma, bronchitis, emphysema)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you ever lose consciousness or control of your balance due to chronic dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. In the past year, have you had chest pain? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you currently being treated for a bone or joint problem that affects your mobility? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you have high blood pressure or high cholesterol? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Are you currently taking medicine to control your blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you have a family history of heart attacks or strokes before age 55? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you been hospitalized recently? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you smoke? |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Are you currently taking any medications? Please list below: |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. 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:
