HEALTH HISTORY QUESTIONNAIRE 2026/2027

THE Fitness Center

This form is valid one year from the date it is filled out. It is the individual's responsibility to inform the Lifestyle & Wellness staff of any changes in one's health status and to complete an updated Health History form.

Please answer the following questions honestly. (Please circle YES or NO)

1. Have you ever been treated for any heart or cardiovascular condition?	YES	NO
2. Do you have a history of high blood pressure?	YES	NO
3. Do you have a pacemaker or automatic defibrillator implanted?	YES	NO
4. Do you have chest pain at rest or upon exertion?	YES	NO
5. Do you have (or had) a history of Diabetes?	YES	NO
6. Do you have a history of high cholesterol or elevated LDL levels?	YES	NO
7. Do you have a family member that has experienced a heart attack or bypass surgery prior to age 50?	YES	NO
8. Do you have or have you been treated for Cancer?	YES	NO
9. Do you have asthma, COPD, shortness of breath or any other lung/respiratory condition?	YES	NO
10. Do you have any chronic pain or arthritis?	YES	NO
11. Do you have hearing or vision impairments?	YES	NO
12. Do you have any skin infections, open wounds or rashes that may affect pool participation?	YES	NO
13. Do you require assistance of an aide or other assistive equipment?	YES	NO
14. Do you have Cognitive Issues or Neurological Disorders?	YES	NO
15. Do you have any Orthopedic conditions/concerns?	YES	NO
16. Do you have (or had) any Spinal Cord conditions or surgeries?	YES	NO
17. Have you had any surgeries/joint replacements in the past two years?	YES	NO
18. Have you received Physical Therapy in the last year?	YES	NO
19. Do you have any injuries or illnesses that may hinder your ability to participate in an exercise program at Boca West Country Club?	YES	NO
20. Do you have permission from your family physician to exercise?	YES	NO

If you answered YES to any of the foregoing, please elaborate: _____

_____

_____

List any allergies (if applicable): _____

_____

HEALTH HISTORY QUESTIONNAIRE 2026/2027

The Fitness Center

The following information is needed so we may send a referral form to your physician.

Member's Name: _____ Member #: _____

Email Address: _____ Date: _____

Telephone #: (____) _____ Age: _____ D.O.B: ___/___/____

Physician's Name: _____

Physician's Phone #: _____

Physician's Fax #: _____

Disclaimer

I authorize Boca West Country Club to share this information with the physician listed on this form. **I understand that physician approval is not required for me to begin training,** and I confirm that I am capable of safely participating in the physical activities I have chosen.

I acknowledge that if I have high blood pressure, it is my responsibility (not that of my trainers) to monitor my blood pressure prior to any training session, if necessary. If my physician has provided specific recommendations or restrictions, I understand that these must be followed. If my blood pressure exceeds acceptable levels (160/90), I understand that training will not be permitted until it is within a safe range.

I acknowledge that it is my responsibility to monitor and understand the effects of any medications I am taking, including any side effects, limitations, or changes that may impact my ability to safely participate in physical activity. I agree to communicate any concerns that I may have regarding my medications and doing physical activity.

The Fitness Center and its staff are not responsible for monitoring, managing, or advising on medication use, dosage, blood pressure, or any medical advice.

By signing below, I hereby release, indemnify, and hold harmless Boca West Country Club and employees from any and all claims, liabilities, injuries, or losses that may arise as a result of any pre-existing medical conditions, injuries, or any inaccurate information I have provided on this form. I accept full responsibility for any risks or complications associated with my participation and my health status.

Signature: _____ Member #: _____