



Hui Ho'ola Maika'i Program

Health Form

How did you hear about us: (Check all that apply)

- Friend Flyer Community Event Other Please explain Other:
- Radio Newspaper Which Community Event?

Name: Gender: Age:

Mailing Address: City: Zip: Phone:

E-Mail Address: Best Way To Contact You:

List Medications you are currently taking:

Physician's Name: Physician's Phone Number:

Does your Physician know that you are participating in a fitness class? YES NO

Do you now or have you had within the past year:

If Yes, Please Explain:

- | | | |
|--|--|----------------------|
| 1. History of heart problems? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 2. High blood pressure? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 3. Difficulty with physical exercise? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 4. Recent surgery (within 3 months) | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 5. Advise from physician not to exercise? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 6. Muscle, joint or back disorder that could be aggravated by physical activity? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 7. History of lung problems? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 8. Were you screened in the last year for colon cancer? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 9. Have you been told you have diabetes? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 10. Have you been told you have high cholesterol? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 11. History of heart problems? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 12. Problems with obesity? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 13. Do you smoke or use any other form of tobacco? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |
| 14. Did you smoke or use tobacco in the past? | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/> |

What physical activity do you presently do?

Females Only:

Are you now or have you been pregnant in the last three months? YES NO

Have you had a mammogram in the last year? YES NO

Date of Last Mammogram: Date of Last Pap Test:

Signature of Client **(OR)**
(Parent/Guardian Signature for Client if UNDER 18 years old)

PRINT NAME: Date: