Print Form

HO'OLA LAHUI HAWAI'I
PHARMACY FITNESS CENTER
KAUA'I COMMUNITY HEALTH CENTER

Hui Ho'ola Maika'i Program

Health Form

Submit Form by E-mail

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

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: