PALMETTO HEALTH

Health Questionnaire for Healthy Aging Program Initiative

Confidentiality Statement

Palmetto Health (PHA) recognizes that patients expect and deserve that all information pertaining to them be strictly limited only to those who need to know that information. Palmetto Health considers a breach of confidentiality to be a serious event and considers any inappropriate disclosure of patient or business information a violation of trust that jeopardizes the mission and survival of the organization.

Please carefully review this form; feel free to contact us if you have any questions.

THE PROGRAMS ARE SELF-MONITORED BY HEART RATE AND PERCEIVED EXERTION. REASONABLE CARE SHOULD BE TAKEN BY THE PARTICIPANT IN ORDER TO AVOID INJURY, ILLNESS, OR AN EMERGENCY SITUATION

(PLEASE PRINT CLEARLY)

Name: _____ Date of Birth: _____ Sex: _____

Address: _____ City:_____ State: _____ Zip: _____

Daytime Telephone: _____ E-mail Address:_____

Name of Primary Care Physician: _____

Physician's Office Telephone Number: _____

Name of Emergency Contact:_____

Phone Number(s):_____

HEALTH HISTORY

Part 1- Known Cardiovascular Problems:

Heart Attack: Yes_____ If "Yes", When? _____ No_____

Stroke: Yes_____ If "Yes", When? _____ No_____

Hypertension: Yes_____ No_____

Other: _____

Please list any surgeries you have undergone as a result of cardiovascular problems:

_____

Please list the name and phone number of a cardiologist (or other applicable specialist) we would contact in case of emergency:

_____

Part 2- Known Arthritis or other degenerative bone or joint diseases:

Yes_____ No_____

If Yes, Describe: _____

Please list any surgeries you have undergone as a result:

_____

Please list the name and phone number of an orthopedist (or other applicable specialist) we would contact in case of emergency:

_____

Part 3- Other known diseases or conditions (including, but not limited to: diabetes, lung disease, and epilepsy) which may affect your participation in an exercise program:

Yes_____ No_____

If Yes, Describe: _____

Please list any surgeries you have undergone as a result:_____

_____

Please list the name and phone number of any applicable specialist we would contact in case of emergency:

_____

Part 4- Known Symptoms:

a. Back Pain: Yes_____ No_____

If Yes, Describe: _____

b. Chest Pain: Yes_____ No_____

If Yes, Describe: _____

c. Joint Pain: Yes_____ No_____

If Yes, Describe: _____

d. Other Pain: Yes_____ No_____

If Yes, Describe: _____

e. Shortness of Breath: Yes_____ No_____

If Yes, Describe: _____

Part 5- Medications: *(PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING)*

1._____	5._____	9._____
2._____	6._____	10. _____
3._____	7._____	11. _____
4._____	8._____	12. _____

Please list any medication(s) that you are allergic to:_____ _____

Mail forms (Health Questionnaire, Physicians Clearance and Informed Consent) to:

HAPI, #15 RMP, Ste. 203, **Columbia, SC 29203** or

Fax to (803)434-3773