

Butler University Employee Fitness Assessment Health History

This form is not a substitute for a thorough physical examination/assessment by your physician. This is designed to identify and understand potential issues that may arise during an increase in physical activity. All information on this form is personal and confidential and will not be released to anyone outside the Fitness Center or your personal trainer without written consent. Any information that you provide will enable us to better understand you and your health/fitness habits.

PERSONAL INFORMATION:

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Gender: _____

Occupation: _____ Butler Employee : Yes No

Current Address: _____

Current Phone Number: _____ Email: _____

Does your physician know you are participating in this exercise program? Yes No

PHYSICIAN INFORMATION:

Physician's Name: _____ Physician's Phone: _____

Address: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

SECTION 1– OVERALL MEDICAL HISTORY

2. Do you have a history of, or do you currently have any of the following (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> History of heart problems, chest pain, or stroke | <input type="checkbox"/> History of breathing or lung problems |
| <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Muscle, joint, or back pain |
| <input type="checkbox"/> Any chronic illness or condition | <input type="checkbox"/> Any previous injury still affecting you |
| <input type="checkbox"/> Difficulty with physical exercise | <input type="checkbox"/> Diabetes or thyroid condition |
| <input type="checkbox"/> Advice from physician not to exercise | <input type="checkbox"/> Cigarette smoking habit |
| <input type="checkbox"/> Any recent surgeries | <input type="checkbox"/> More than 20% over ideal body weight |
| <input type="checkbox"/> History of heart problems in immediate family | <input type="checkbox"/> Increased blood cholesterol |
| <input type="checkbox"/> Pregnancy (now or within the last 3 months) | <input type="checkbox"/> Hernia or any condition that may be aggravated with exercise |

2a. If you checked any of the above conditions, please explain here:

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SECTION 2—PAST MEDICAL HISTORY*

3. Have you ever been diagnosed with, or suffered from (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Defibrillator/rhythm disturbance |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Heart valve disease |
| <input type="checkbox"/> Cardiac catheterization | <input type="checkbox"/> Heart failure |
| <input type="checkbox"/> Coronary angioplasty (PTCA) | <input type="checkbox"/> Heart transplant |
| <input type="checkbox"/> Pacemaker/implantable cardiac | <input type="checkbox"/> Congenital heart disease |

3a. If you checked any of the above conditions, please explain here:

SECTION 3—CURRENT MEDICAL HISTORY*

4. Have you ever experienced any of the following (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Pain or discomfort in the chest with mild exertion | <input type="checkbox"/> Back/neck pain and/or discomfort |
| <input type="checkbox"/> Excessive breathlessness | <input type="checkbox"/> Orthopedic problems |
| <input type="checkbox"/> Unusual shortness of breath/fatigue with usual activities | <input type="checkbox"/> Heart murmur and/or palpitations |
| <input type="checkbox"/> Difficult, labored, or painful breathing during day/night | <input type="checkbox"/> Musculoskeletal problems |
| <input type="checkbox"/> Dizziness, fainting, or blackouts | <input type="checkbox"/> Severe headaches/migraines |

4a. If you checked any of the above conditions, please explain here:

5. Cardiovascular Risk Factors (check all that apply)**:

- | | |
|---|--|
| <input type="checkbox"/> Your sex assigned at birth is male and you are older than 45 years | <input type="checkbox"/> Your sex assigned at birth is female and you are older than 55 years or had a hysterectomy/postmenopausal |
| <input type="checkbox"/> You have elevated cholesterol levels | <input type="checkbox"/> History of heart attack/sudden death in immediate family |
| <input type="checkbox"/> You smoke currently or within the past 6 months | <input type="checkbox"/> You are diabetic or take medicine to control blood sugar |
| <input type="checkbox"/> Your blood pressure is \geq 140/90 | <input type="checkbox"/> You are physically inactive (get <30 min of moderate physical activity most days) |
| <input type="checkbox"/> You take blood pressure medication | <input type="checkbox"/> You are more than 20lbs. overweight |
| <input type="checkbox"/> You have elevated fasting blood glucose levels/A1C | <input type="checkbox"/> NONE OF THE ABOVE STATEMENTS ARE TRUE |

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SECTION 4—MEDICATIONS:

6. Please list below all prescription and over-the-counter medications you are currently taking (please print clearly) or attach a typed list with the information:

Medicine	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6a. Are there any medications that your physician has prescribed for you in the past 12 months that you are no longer taking?

Yes No

If yes, please list the medications (please print clearly):

SECTION 5—DIET/NUTRITION HISTORY:

7. How many meals do you typically eat per day? _____

Do you skip meals? If so, which one most commonly? _____

How many snacks do you typically eat per day? _____

7a. Check all that apply:

- You try to eat at least 5 servings of fruits and vegetables a day
- You try to limit the amount of fat you eat to <30% of your total daily caloric intake
- You use sugar sparingly by adding little/none to the foods you eat and by limiting your intake of desserts/candy
- You limit your alcohol consumption to 1-2 drinks or fewer per day
- You limit your sugary, sweetened beverages to 1-2 drinks or fewer per day

7b. Do you have any special dietary restrictions?

Yes No

If you checked yes, please explain here:

SECTION 6—WEIGHT HISTORY

What do you consider to be your ideal body weight? _____

What has been your lowest body weight as an adult? _____

What has been your highest body weight as an adult? _____

What was your weight one year ago? _____

BUTLER UNIVERSITY EMPLOYEE FITNESS ASSESSMENT REGISTRATION

SECTION 1—General Information

Please choose which days you are available to complete a fitness assessment: (Check all that apply)

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Please choose blocks of time you are available to complete a fitness assessment: (Check all that apply)*

6 A.M.—9 A.M. 9 A.M.—12 P.M. 12 P.M.—4 P.M. 4 P.M.—7 P.M. 7 P.M.—11 P.M.

PERSONAL FITNESS GOALS:

Please indicate your personal fitness/health goals: (Check all that apply)

- Reduce body fat & lose weight Better balance & mobility
 Build lean muscle mass Improve cardiovascular fitness
 Improve stamina & flexibility General health & fitness
 Muscular strength Reduce blood pressure/cholesterol
 Other: _____

Do you currently engage in exercise or physical activity? Yes No

If yes, what kind of physical activity do you engage in and how many times a week? _____

Butler University, the Department of Recreation and their agents, assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name (Last, First, M.I.) _____

Signature: _____ Date: _____

BUTLER UNIVERSITY HEALTH AND RECREATION CENTER
RELEASE OF LIABILITY AND AGREEMENT TO INDEMNIFY

In consideration of Butler University ("University") allowing me (1) to access and use its Health and Recreation Center, including, but not limited to, its fitness, swimming and shower/locker facilities and equipment (collectively referred to hereinafter as the "HRC"), and/or (2) to participate in fitness or wellness activities organized or offered by the University (either (1) or (2) or both (1) and (2) collectively referred to hereinafter as "Use of HRC and Participation in Activities") I, the undersigned, for myself and my heirs, next of kin, assigns, and personal representatives, do hereby agree to the following conditions:

I understand and acknowledge that my Use of HRC and Participation in Activities are potentially hazardous and involve risks, inherent and otherwise, that cannot be eliminated and which may cause injury, illness, paralysis, permanent disability, or death to myself, other persons, and/or damage to property. I understand that negligence of the University and other risks associated with my Use of HRC and Participation in Activities may cause injury, illness, paralysis, permanent disability, or death to myself, other persons, and/or damage to or loss of property. Some of the risks associated with my Use of HRC and Participation in Activities include, but are not limited to, equipment failure, known or unknown medical conditions, improper use of equipment, acts of others, and latent or patent defects or dangerous conditions in the HRC. I accept full and sole responsibility for all risks, both known and unknown, inherent or otherwise, related to my Use of HRC and Participation in Activities and acknowledge that I am voluntarily using the HRC and participating in activities even with knowledge of these risks.

Acknowledging that such risks exist, I hereby **RELEASE AND DISCHARGE** the University, its affiliates, and their respective officers, representatives, managers, members, directors, owners, agents, contractors, employees, insurers, and each of them and/or anyone associated in any way with my Use of HRC or Participation in Activities (the "University Group"), to the fullest extent permitted by law, from any and all claims, damages, losses, actions, suits, proceedings, expenses, attorney fees, costs, and liability that I, anyone on my behalf, my heirs, next of kin, assigns or personal representatives might have for or relating to any injury to my person or property suffered or claimed to have been suffered by me which arises out of or is related in any manner to my Use of HRC or Participation in Activities, including, but not limited to, any claim that the act or omission complained of was **caused in whole or in part by the strict liability or negligence in any form of the University Group.**

I further agree to **INDEMNIFY, HOLD HARMLESS, AND DEFEND** the University Group in any action or proceeding from and against all alleged liability, claims, causes of action, damages, losses, suits, proceedings, expenses, attorney fees and costs arising out of or related in any manner to my Use of HRC or Participation in Activities or for my failure to comply with the terms of this Release of Liability and Agreement to Indemnify. This agreement to indemnify, hold harmless and defend applies even if the act or omission complained of was allegedly **caused in whole or in part by the strict liability or negligence in any form of the University Group.**

This document is governed by the laws of the State of Indiana, and any cause of action relating to the interpretation or enforcement of this document is subject to the exclusive jurisdiction of a court in Marion County, Indiana. If one or more portions of this document are found to be unenforceable, the remainder of the document will remain enforceable.

I have read and fully understand this Release of Liability and Agreement to Indemnify and agree to be bound by its terms. I understand that by signing this document I am waiving certain legal rights, including the right to sue the University Group. I sign this document freely and willingly.

READ! YOUR LEGAL RIGHTS ARE AFFECTED!

Participant Signature

Date

Print Participant Name and Age