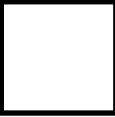


OFFICE USE ONLY  Waiver	<input type="checkbox"/> Current Member <input type="checkbox"/> New /Re-joining	Pre-Activity Screening: Resting Blood Pressure _____ ; _____ Resting Heart Rate _____ Ht. _____ Wt. _____ BMI _____ <input type="checkbox"/> Self-reported <input type="checkbox"/> Actual Measurement MOD Initials _____ Date _____
	<input type="checkbox"/> Guest <input type="checkbox"/> Diabetes Prog.	
	PAVs: Minutes of exercise per week: _____ < 150 _____ > 150 Waist Circumference _____	
	PCF Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	

GE FITNESS CENTER– Health Profile

Physician's consent may be requested prior to participation for certain health conditions. All information will remain strictly confidential.

Last Name _____ **First Name** _____ **Middle Initial** _____

SSO (Single Sign On) or Member # _____

Male Female Birthday (mo./day/yr.) ___/___/___ Age _____

GE Employee GE Retiree Spouse of GE Emp./Retiree Dependent Co-op Contractor

Home Mailing Address _____

City _____ State _____ Zip _____ Email Address _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

In case of emergency notify _____ Phone (____) _____ - _____

Physician's Name _____ **Address** _____

Physician Phone (____) _____ - _____ Physician Fax (____) _____ - _____

Do you currently have any of the following health conditions? (Please circle "Y" or "N")

- Y N Hypercholesterolemia, total cholesterol greater than 200 mg/dL **OR** HDL less than 35 mg/dL, **OR** on cholesterol lowering medication. Number _____?
- Y N Hypertension, blood pressure greater than or equal to 140/90 mmHg, **OR** on hypertension medication
- Y N Smoking habit (current)
- Y N Average less than 30 minutes of physical activity per day, i.e. exercise, gardening, vacuuming, walking, weight lifting
- Y N MEN: Are you 45 years of age or older?
- Y N WOMEN: Are you 55 years of age or older?

Do you have a history of any of the following diseases?

Heart/Vascular problems (please specify)

- Y N Heart disease, heart attack, angina When? _____
- Y N Coronary angioplasty/cardiac surgery When? _____
- Y N Rapid heartbeats (greater than 100bpm)/palpitations
- Y N Heart murmurs or unusual cardiac findings
- Y N Peripheral vascular disease
- Y N Aneurysm When? _____
- Y N Stroke When? _____
- Y N Other cardiac condition _____

Disease/ Disorders (please specify)

- Y N Kidney disease or other organ disease _____
- Y N Thyroid or metabolic disease _____
- Y N Multiple sclerosis _____
- Y N Diabetes _____
- Y N Other diagnosed disease/ disorder _____

Respiratory Problems (please specify)

- Y N Asthma _____
- Y N Chronis bronchitis _____
- Y N Emphysema or COPD (chronic pulmonary obstructive disease)

Do you have a history of the following?

- Y N Fainting or dizziness
- Y N Chest discomfort at rest or during exertion
- Y N Unusual fatigue or shortness of breath
- Y N Ankle Swelling
- Y N Abnormal EKG
- Do you have a history of any of the following?
- Y N Orthopedic problems (joint/bone) withing the past 6 months?

- Y N Chronic back problems

- Y N Arthritis

- Y N Major surgery/hospitalization (within last 6 months)

- Y N Pregnancy current or within 2 months postpartum

Medications you are currently taking:

Reason:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

- _____
- _____
- _____
- _____
- _____

Are you allergic to any medication? Yes No

If yeas, please explain:

I verify that all information is accurate and I understand that it is my responsibility to update the fitness staff of any changes in health status that would alter my ability to safety participate in GE Fitness Center activities.

Signature _____

Date _____

Payment Options

Payroll Deduction (Current GE Employees)

Credit Card/Check

Cost per month \$ _____

Circle one: Weekly Bi-Weekly Monthly

Single –Employee/dependent only

Multiple– Employee and/or dependents

Complete dependents information only if a multiple payroll deduction is requested:

Dependent's Full Name _____

DOB ___/___/___

Dependent's Full Name _____

DOB ___/___/___

Dependent's Full Name _____

DOB ___/___/___

Authorization for Payroll Deduction: I hereby authorize payroll deductions for membership to the GE Fitness Center. I understand that the monthly fee may be adjusted from time to time and this authorization remains in effect for the adjusted fee schedule.

Signature of GE Employee

Date