

Cannon Memorial Hospital Wellness Department  
Wellness Program Registration Form

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Section A

Name \_\_\_\_\_ Sex \_\_\_\_ (M) \_\_\_\_ (F) Age \_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_ Marital Status \_\_\_\_ (S) \_\_\_\_ (M)  
Home Phone # \_\_\_\_\_ Work \_\_\_\_\_ May We contact you at work? \_\_\_\_ (Yes) \_\_\_\_ (No)  
Are you a CMH Employee/Volunteer? \_\_\_\_ (Yes) \_\_\_\_ (No) Class Time \_\_\_\_\_ Family/Other Physician \_\_\_\_\_

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Medical History

Section B

Are you currently experiencing any health problems? \_\_\_\_ (Yes) \_\_\_\_ (No) If yes, describe \_\_\_\_\_

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2. Do you smoke? \_\_\_\_ (Yes) \_\_\_\_ (No) If yes, specify how long and how much \_\_\_\_\_  
Is there a family history of heart or other artery disease in parents or siblings prior to age 55? \_\_\_\_ (Yes) \_\_\_\_ (No)  
If yes, please specify relationship \_\_\_\_\_ Age \_\_\_\_\_

3. Please check the appropriate spaces if you have or are being treated for any of the following:  
\_\_\_\_ Diabetes (Onset) \_\_\_\_ Medication \_\_\_\_\_ Diet only \_\_\_\_ (Yes) \_\_\_\_ (No)  
\_\_\_\_ Elevated Cholesterol Level Last reading \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_ High Blood Pressure Last reading \_\_\_\_\_ Date \_\_\_\_\_ Medication \_\_\_\_\_  
\_\_\_\_ Heart Disease (Please be Specific) \_\_\_\_\_ Medication \_\_\_\_\_  
\_\_\_\_ Stroke (Medication) \_\_\_\_\_  
\_\_\_\_ Asthma (Medication) \_\_\_\_\_  
\_\_\_\_ Epilepsy (Medication) \_\_\_\_\_  
\_\_\_\_ Back Injury (Please be specific) \_\_\_\_\_  
\_\_\_\_ Orthopedic problems (Please be specific) \_\_\_\_\_  
\_\_\_\_ Arthritis/Bursitis \_\_\_\_\_  
\_\_\_\_ Any muscular weakness or injuries (Medication) \_\_\_\_\_ (Treatment) \_\_\_\_\_  
\_\_\_\_ Allergies (Allergy medication) \_\_\_\_\_ Allergy shots \_\_\_\_ (Yes) \_\_\_\_ (No)  
\_\_\_\_ Other medical problems (Please be specific) \_\_\_\_\_ (Medication) \_\_\_\_\_  
\_\_\_\_ Any over the counter medication (Please list) \_\_\_\_\_

4. Please check the appropriate spaces if you experience any of the following:  
\_\_\_\_ Chest Pain \_\_\_\_\_ Ankle swelling \_\_\_\_\_ Shortness of breath  
\_\_\_\_ Irregular heart beat \_\_\_\_\_ Heart murmur \_\_\_\_\_ Fainting \_\_\_\_\_ Dizziness

5. What is the date of your most recent medical examination? \_\_\_\_\_

6. Have you ever had an EKG? \_\_\_\_ (Yes) \_\_\_\_ (No) Date \_\_\_\_\_

7. Any major illness or hospitalization within the last 6 months, including childbirth? \_\_\_\_ (Yes) \_\_\_\_ (No)  
If childbirth, when? \_\_\_\_\_

8. Are you pregnant? \_\_\_\_ (Yes) \_\_\_\_ (No) Due Date \_\_\_\_\_

9. Have you been doing some type of exercise on a regular basis? \_\_\_\_ How Often \_\_\_\_ How many months \_\_\_\_

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### Consent for Participation

I, the undersigned applicant for and in consideration for the benefit to be derived by participation in the program elected in Section A, do hereby release and forever discharge Cannon Memorial Hospital, its agents, servants, representatives, and staff from and against any and all liability and responsibility for any injury, illness or sickness which may result from participation in the Cannon Memorial Hospital activities or programs elected, and so hereby further agree to indemnity and hold harmless Cannon Memorial Hospital, its agents, servants and employees from any and all liability in such regard.

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\_\_\_\_\_  
Applicants Signature (If under 18 must be signed by parent or legal guardian)

\_\_\_\_\_  
Date

### **Refund Policy**

Policy: Refunds for classes will be granted with proper excuse of non-attendance

Procedure:

1. Individuals may receive a full refund before the class starts without any documentation.
2. Individuals may receive a full or prorated (if class has already started) refund with documentation of the following:
  - a. A medical problem (participant or family member) can be refunded with doctor's excuse.
  - b. A person moving outside a thirty-mile parameter of call can be refunded with proof of address and telephone number
  - c. Death (participant or family member).
3. Refund will be considered and granted by program coordinator or director.