

# AJR Motor Centre

## Confidential Health History Form

<b>Contact Information:</b>		Date:	
Name:			
Address:			
Telephone:		Email:	
Date of Birth:		Height:	Weight:
In Case of Emergency Contact:			
Phone:		Relationship:	
<b>Medical Information:</b>			
Physician:		Phone:	
Are you currently under a doctor's care?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please explain:			
Have you ever had an exercise stress test:		Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know? <input type="checkbox"/>	
If yes, were the results		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
Do you take any medications on a regular basis?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please indicate:			
Have you been recently hospitalized?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, explain:			
Are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you smoke?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you drink alcohol more than three times/week?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Do You Have:</b>			
High cholesterol?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Diabetes?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
High blood pressure?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Known heart disease?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Muscle pain or an injury? (Explain on back of Form)		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Rheumatic heart disease?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
A heart murmur?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Chest pain with exertion?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Irregular heart beat or palpitations?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Lightheadedness or do you faint?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Unusual shortness of breath?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Emphysema?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other metabolic disorders (thyroid, kidney etc.)?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
If you answered <b>YES</b> to one or more of the questions above, you must receive a doctor's note <b>BEFORE</b> you can receive a membership. Your note must indicate which question you answered yes to, as well a signature & confirmation from your doctor saying it is alright to participate with our organization, given your current health status.			
I have read, understand & completed the Health History Form		Yes <input type="checkbox"/> No <input type="checkbox"/>	
All questions have been answered to the best of my knowledge		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Signature:		Date:	
Signature of Parent:		Witness:	
(or Guardian for participants under age 15)			

105 Connell Park Road, Woodstock, NB E7M 1M5 | (506) 325-4671  
[ayrmotorcentre@town.woodstock.nb.ca](mailto:ayrmotorcentre@town.woodstock.nb.ca) | [www.town.woodstock.nb.ca](http://www.town.woodstock.nb.ca)

Date Received :	Office Staff Signature:
-----------------	-------------------------

Updated August 2020