+rmc HEALTHPLEX at the Regional Medical Center

Circle Employee Status:
Active Employee - Active Family
Affiliate Employee - Affiliate Family

HEALTH HISTORY QUESTIONNAIRE

Name: _____ D/O/B:_____ Age: _____

Address: _____ City: _____

State: _____ Zip: _____ Tel #: (_____)_____

Primary MD: _____ Specialist MD: _____

Email address: _____ Emergency Contact #: _____

SECTION ONE: RISK FACTOR PROFILE

1. Height: _____ ft. _____in. Weight: _____lbs. BMI ≥ 30 (Staff will calculate) YES NO
2. Has a parent or brother/sister had a heart attack, bypass surgery, or other heart disease prior to their age of 55 (male) or age 65 (female)? YES NO
3. Do you presently smoke or have you quit smoking within the past 6 months? YES NO
4. Do you have high blood pressure or take medicine for high blood pressure? YES NO
   Do you know your resting Blood Pressure: Systolic _____ Diastolic: _____
5. Do you have high cholesterol or take cholesterol-lowering medication? YES NO
   Do you know your: HDL (Good) cholesterol value _____mg/dL
   LDL (Bad) cholesterol value _____mg/dL
   Triglycerides _____mg/dL
6. Do you have high blood glucose, or have you been told you have Diabetes? YES NO
7. Is your Fasting Blood Glucose greater than 100 mg/dL? YES NO
8. Are you currently in an exercise program? YES NO

SECTION TWO: GENERAL MEDICAL HISTORY

1. Have you been hospitalized or have you had major surgery within 1 year? YES NO
   Please specify:_____
2. Do you have a history of any of the following conditions:
   - Cancer (Type: _____ Date_____) YES NO
   - Renal (Kidney) Disease/ Failure YES NO
   - Liver Disease (Cholestasis, Cirrhosis, or Hepatitis) YES NO
   - Thyroid Disorder YES NO
   - Neurological Disorders (i.e., Alzheimer's, MS, or Parkinson's) YES NO
   - Diabetes: ☐ Type 1 ☐ Type 2 YES NO

SECTION THREE: CARDIOPULMONARY HISTORY

A. Have you had any of the following?

1.	Angina or Chest (Heart) Pain/ Discomfort	YES	NO	☐ Current
2.	Myocardial Infarction/ Heart Attack	YES	NO	Date_____
3.	Heart Bypass Surgery	YES	NO	Date_____
4.	Heart Valve Surgery	YES	NO	Date_____
5.	Angioplasty (balloon, laser, roto rooter)	YES	NO	Date_____
6.	Stent Placement	YES	NO	Date_____
7.	Congestive Heart Failure	YES	NO	Date_____
8.	Pacemaker	YES	NO	Date_____
9.	Implantable Cardioverter Defibrillator (ICD)	YES	NO	Date_____
10.	Stroke/ TIA	YES	NO	Date_____
11.	Heart Arrhythmias/ Irregular Heart Beat	YES	NO	Date_____
12.	Other surgery or problems related to your heart	YES	NO	Date_____
	Please specify: _____			
13.	Peripheral Vascular Disease (PVD)	YES	NO	
14.	Leg Bypass/ Angioplasty (Balloon, Stent)	YES	NO	Date_____

B. Have you had any of the following symptoms **within the last 12 months?**

1.	"Palpitations" or "skipped beats" in your heart	YES	NO	☐ Current
2.	Rapid heart rates at rest	YES	NO	☐ Current
3.	Dizziness or fainting	YES	NO	☐ Current
4.	Swollen feet or ankles	YES	NO	☐ Current
5.	Severe shortness of breath at rest or with usual activities	YES	NO	☐ Current
6.	Severe pain in legs with usual activities (i.e., walking, stair-climbing)	YES	NO	☐ Current
7.	Orthopnea/ Nocturnal Dyspnea	YES	NO	☐ Current
8.	Known heart murmur	YES	NO	☐ Current

Have you had a Stress Test (Treadmill) within the last year OR? YES NO

If YES, **who** was the doctor that performed the test? _____

When was it performed? _____ **Where** was it performed? _____

C. Do you currently suffer from any of the following Pulmonary diseases?

1.	Chronic Obstructive Pulmonary Disease (COPD)	YES	NO
2.	Emphysema	YES	NO
3.	Chronic Bronchitis (chronic cough & excessive sputum production)	YES	NO
4.	Severe Asthma	YES	NO
5.	Pulmonary Fibrosis	YES	NO
6.	Asbestosis	YES	NO
7.	Sleep Apnea	YES	NO
8.	Have you ever had a lung surgery? Date_____	YES	NO
9.	Do you currently use "inhalants" for allergies or to breathe better?	YES	NO
10.	Do you use oxygen at home?	YES	NO

a. If **YES**, how much oxygen do you use? _____ liters/minute

b. If **YES**, how much oxygen do you use during exercise or exertion? _____ liters

SECTION FOUR: MUSCULOSKELETAL HISTORY

1. Has a physician ever told you that you have a bone or joint problem that may be made worse with exercise? YES NO
   Please specify:_____
2. Have you ever had orthopedic surgery? YES NO
   Date:_____ **Please specify:**_____
3. Have you recently required Physical Therapy (within last 12 months)? YES NO
   Date:_____ **Please specify:**_____
4. Do you have a history of the following?

   ☐ Severe or chronic low back pain
   ☐ Spinal disc problems
   ☐ Arthritis of the spine
   ☐ Degeneration of the spine
   ☐ Spondylosis
   ☐ Moderate to severe osteoporosis
   ☐ Osteoarthritis/ Rheumatoid arthritis
   ☐ Fibromyalgia
   ☐ Neuropathy
   ☐ Severely broken bone(s)

5. Please list any other medical conditions or concerns that may affect your exercise program.

   _____

   _____

   _____

6. Please list your current medications.

NAME OF MEDICATION	DOSE	FREQUENCY

I understand that accurate information about my health history is required to determine the safest most effective exercise program for me. I declare that information provided on this health history questionnaire is true and accurate to the best of my information, knowledge, and belief.

Signature: _____ Date: _____

Email: _____

RELEASE AND WAIVER

One purpose of the RMC HEALTHPLEX is to promote healthy living activities among participants. One of those activities is regular exercise which can lead to many health benefits. While regular exercise is a desired activity in healthy living there are risks for participants engaging in exercise, particularly those with certain medical conditions or those who engage in strenuous exercise beyond appropriate levels of one's physical condition.

The Regional Medical Center of Orangeburg and Calhoun Counties (RMC) recommends regular physician evaluations as a part of a healthy living regiment and such evaluation may be particularly recommended before beginning an exercise program. Prior to participation in exercise activity at RMC's HEALTHPLEX participants will be provided with a health appraisal questionnaire. This questionnaire is not a substitute for a medical exam, but is simply a simple screening technique to identify any serious or significant risk in connection with your participating in physical activity available at RMC's HEALTHPLEX. If, in response to the simple questionnaire, the risk of you engaging in an exercise program is deemed to be moderate or high we will recommend that you contact your physician to determine the appropriateness of such activity. We will not, however, require an evaluation by a physician.

As it is not practical for RMC to perform a complete physical screening technique, as a participant in physical activity at RMC we require prior to participation that you sign the below described waiver and assumption of the risk confirmation and indemnification to confirm that you assume the risk of any injuries resulting from any health condition that you may have as a result of undo stress on portions of your body. If your questionnaire indicates moderate or high risk, you may be a higher risk for injury or death.

With all persons we recommend that physical activity be limited or moderate initially if you do not have a history of participating in an exercise regimen.

WAIVER

In consideration of permission to use, today and on all future dates, the property, facilities, and services of RMC and RMC's HEALTHPLEX, for myself, my heirs, personal representatives or assigns, do hereby release, waive, discharge, and covenant not to sue RMC, its directors, officers, employees, and agents from liability from any and all claims resulting in personal injury, accidents, or illness (including death), and property loss arising from, but not limited to, participation in activities, observation, and use of the facilities, premises, or equipment.

_____ _____

Signature of Client Date

ASSUMPTION OF RISKS

Physical activity, by its very nature, carries certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. RMC has and provides facilities such as strength training, walking, jogging, aerobic activities, and exercise. Some of these risks involve exertions of strength using various muscle groups, some involve quick movements involving speed and change of direction, and others involve sustained physical activity which places stress on the cardiovascular system and body.

The specific risks vary from one activity to another, but in each activity the risks range from 1) minor injuries such as scratches, bruises, and sprains to 2) major injuries such as eye injury or loss of sight, joint, muscle, bone or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in the activities made possible by RMC and RMC's HEALTHPLEX. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

INDEMNIFICATION AND HOLD HARMLESS

I also agree to indemnify and hold RMC harmless from any and all claims, actions, suits, procedures, costs, expenses, damages, liabilities, including attorney fees brought as a result of my involvement with the fitness and exercise facilities of RMC and to reimburse them for any such expenses incurred.

SEVERABILITY

The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of South Carolina and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

FORUM/WAIVER OF JURY TRIAL

I agree that if legal action is brought relating to any activity described herein, that said litigation must be filed in Orangeburg County, South Carolina. I further agree. on behalf of myself and my child(ren) or heir(s), (if applicable) along with RMC to hereby waive any right to request a jury trial in any such litigation, regardless of the nature of the claim or theory of recovery.

ACKNOWLEDGMENT AND UNDERSTANDING

I have read this wavier of liability, assumption of risks, indemnity agreement, severability and forum/waiver of jury trail, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the agreement freely and voluntarily and intend my signature to be complete and an unconditional release of all liability to the greatest extent allowed by law. I also understand the terms of my usage of all of RMC's facilities and I have been offered a completed and signed copy of this contract.

_____ _____

Signature of Client Date

Billing Information is Required for Membership

Credit Card Billing

I authorize a monthly charge to be deducted from this account

Account #: _____
CVS Number: _____
Expiration Date: _____

Print your Name as it appears on the Card: _____.

Signature: _____ Date: _____.

Bank Draft Billing

I authorize a monthly charge to be deducted from this account

Bank Name and Branch: _____.
_____.
_____.

Routing Number: _____.
Account Number: _____.

Please provide a copy of a voided check

Signature: _____ Date: _____.

HEALTHPLEX MEMBERSHIP RATES:

HOURS OF OPERATION
5:00 am – 10:00 pm, 7 days a week

$25 Single Membership per month

$40 Family Membership per month*

*** includes spouse and 1 child ages 16-26 or no spouse and up to 2 children ages 16-26. Additional children may be added for $10/ month per child.**

Membership billing will occur monthly. All cancellations must be made by written notification and provided in person to the HEALTHPLEX.

Membership allows access to all 5 HEALTHPLEX locations.

1. RMC Annex | HEALTHPLEX
2. Branchville | HEALTHPLEX
3. Holly Hill | HEALTHPLEX
4. Saint Matthews | HEALTHPLEX
5. Santee | HEALTHPLEX

NO ANNUAL CONTRACTS

+rmc
HEALTHPLEX
at the Regional Medical Center

RULES, REGULATIONS AND WAIVER

SECTION ONE: GENERAL FACILITY USAGE

A. Facility Closings

1. The center may be closed on and around the following holidays: New Year's Day, Easter, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas.
2. The center may periodically close for maintenance and repairs as needed.
3. No refunds or credits will be provided for these short-term occurrences.
4. All changes to the regular hours of operation or services will be posted in advance.

B. General Facility Regulations

1. No fragrances of any kind are permitted in the facility. This includes perfume, lotion, powder, cologne, and hair care products. (some of our pulmonary patients are affected by these)
2. No solicitation of any kind is permitted. This includes verbal solicitation and printed materials, unless specifically approved by the Director.
3. Alcohol consumption/possession, weapons, smoking and the use of smokeless tobacco/ electronic cigarettes are strictly prohibited in and around the facility.
4. Neither RMC nor HEALTHPLEX are responsible for lost, misplaced, stolen or damaged items.

C. Membership Cards

1. Each member will be provided a membership FOB upon registration for a $5.00 fee.
2. All members are required to scan their FOBs at each visit. Failure to present proper identification upon entry or request may result in denial of entry.
3. Lost FOBs will require a replacement fee.

D. Gym Etiquette

1. Shoes must be worn at all times in the gym area. No bare or socked feet are allowed.
2. The following types of shoes are **NOT** allowed: open toed or open heeled shoes, sandals, flip-flops, or crocs.
3. All participants utilizing the facility must be clothed appropriately. This may include warm-up suits, t-shirts, shorts, athletic/rubber soled shoes, tights and conservative leotards. Clothing or belts with sharp or abrasive buttons/buckles will not be allowed on the equipment. No torn t-shirts or tank tops allowed
4. Please wipe down equipment after use with either a towel or disinfectant wipe.
5. Please limit loitering on and around the exercise equipment while others are waiting.
6. All food and drink must be consumed in designated areas only. Water is allowed on the exercise floor/ aerobics area – no open containers or open cups.
7. No children are allowed on the exercise floor/ aerobics area unless they are members. Guests must remain in the front lobby.

E. Locker Room Etiquette

1. Towels are provided for all individuals using the facility. It is required that members place wet or used/ soiled towels in the dirty towel bins.
2. Please dry off in wet area before using locker room and changing areas.
3. The center provides temporary lockers on a daily basis. Permanent lockers are not allowed. Personal items left in temporary lockers will be removed and placed in Lost & Found.
4. Report any accidents immediately to the staff.

SECTION TWO: MEDICAL INFORMATION

A. Notification

1. Members must notify the staff of medication changes, recent illness, injury, surgery/ procedure, or hospital visits.
2. Members agree to report any unusual signs or symptoms before, during, or after an exercise session to the staff.

B. Clearance to Return

1. Medical (physician) clearance may be required to return to exercise after a surgery/ outpatient procedure, hospitalization, emergency room visit, or severe illness. The center reserves the right to withhold participation until such clearance is received or for non-compliance.
2. Some surgeries/ procedures may require participation/ referral to the cardiopulmonary rehabilitation program prior to return to the independent exercise program.

SECTION THREE: BILLING INFORMATION

A. Billing for Services

1. The center does not require an "annual contract" for membership. As a courtesy, all memberships are on a month-to-month billing service.
2. The member will be responsible for Monthly fees each month.
3. Telephone calls will not be accepted for program termination.
4. Refunds for monthly fees for not attending the center will not be provided.
5. Billing begins at the time of registration.
6. No refunds for pre-paid memberships of multiple months.

_____
Initials

B. Termination/ Suspension of Billing

1. Members will be continuously billed for monthly fees until the member chooses to terminate their membership.
2. Members must submit a "Termination Request" form (available at desk) in order to suspend the monthly billing procedures. **All Termination Requests must be in writing.**
3. Members may suspend their membership for seasonal, travel, health, or personal reasons at any time. Members must submit a Termination Request form to stop billing.
4. No credits/ refunds will be issued for months not attended if notice of resignation was not received or for partial months not attended. Registration fees are non-refundable.

I have read and fully understand the Billing Procedures. I further understand that I will be held accountable for any fees incurred due to my failure to notify the Center of my temporary/ permanent resignation, change in program, or return to exercise. No credits will be issued for partial months.

I agree to abide by all the rules and regulations adopted and published by RMC and HEALTHPLEX and its agents relating to the operation and use of its facilities. I understand that my failure to observe these rules may result in my exclusion from the premises.

I represent that I am physically able to use the equipment and/ or facilities provided. I fully understand and agree that in using the facilities provided, there is the possibility of accidental injury or death. I agree to assume the risk of such injury arising out of or connected with my participation in any activities or the use of any machinery/ exercise equipment at HEALTHPLEX.

Further, I will be personally responsible for any financial costs incurred due to transportation or medical expenses as a result of any injury incurred.

The Regional Medical Center and HEALTHPLEX assume no liability whatsoever for lost, misplaced, stolen, and/ or damaged personal property.

_____ _____/_____/_____

Participant Signature Date

_____

Printed Name

Developed 09/2014
Revised 05/2018