CORPUS CHRISTI REGIONAL
TRANSPORTATION AUTHORITY

HEALTH HISTORY QUESTIONNAIRE

General Information:

Name: ____

Address: ____

City: ___________________________ State: _______ Zip Code: _____________

Home Phone #: _________________ Cell#: _________________ Other: ________________

Date of Birth: _________________ Age: _____ Sex: ________

Emergency Contact:

Name: ____ Relationship: ____________________

Phone #: _______________________ Alternate #: _________________________

Personal Physician: _________________________________ Phone #: _________________________

Physician's Address:

____

Personal History:

Prior to utilizing CCRTA Fitness Centers and in the interest of protecting your health and safety, please answer the following questions to the best of your knowledge. If you answer "Yes" to a question, CCRTA may require you to have your personal Physician complete the "CCRTA Fitness Centers Medical Clearance Form" prior to your utilization of the Fitness Center.

Any information provided next section is voluntary, and will be kept confidential.

1. Are you currently under the care of a physician for any heart problems?

   ___ Yes ___ No

2. Are you now taking medications for your heart or blood pressure?
   ___ Yes ___ No

3. Are you Diabetic?

   ___ Yes ___ No

   If Yes: ___ Type 1 ___ Type 2

4. Within the past three (3) months, have you been hospitalized for illness, accident or surgery?
   ___ Yes ___ No

5. During the past two (2) years have you had chest pain that lasted more than an hour?
   ___ Yes ___ No

6. Have you had an abnormal EKG or heartbeat?
   ___ Yes ___ No

7. Are you allergic to any medication?
   ___ Yes ___ No

8. Are you currently pregnant?
   ___ Yes ___ No

9. Are currently under a physician's care for any other reasons not provided above?
   ___ Yes ___ No

10. If you answered "Yes" to previous question, please explain:

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- Please provide any other relevant information that may be needed to ensure your safety and well-being within the CCRTA Fitness Centers below:

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