AYR Motor Centre

Confidential Health History Form

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

Update June 2017

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Date Received :	***Office Staff Signature:***