Prenatal Enrollment Form

The Fitness Center

UW Medicine
VALLEY
MEDICAL CENTER

Name_____ Date_____

Mailing Address _____

City_____ Zip _____

E-mail Address (optional) _____

Daytime Phone_____ ext._____ Evening Phone _____

Date of Birth_____ Marital Status ☐ Single ☐ Married

Employer_____ Department_____

Person to Notify in Case of Emergency _____ Phone _____

Have you participated in the Prenatal Water Aerobics class at Valley Fitness Center? ☐ Yes ☐ No

If so, when?_____

Type of membership category:

☐ Prenatal Water Exercise class only

☐ Prenatal Water Exercise class & full use of Fitness Center (Additional $21.50 plus tax)

Class section:

☐ Tuesday/ Thursday, 6:45 – 7:30 PM

Medical History

A. HAVE YOU EVER HAD OR HAVE NOW:

☐ Heart Attack (Date:_____)

☐ Coronary Bypass Surgery (Date:_____)

☐ Congestive Heart Failure

☐ Diabetes – Using Insulin

☐ Angina/Chest Pain – please explain: _____

☐ Other Heart Problem – please explain: _____

☐ High Blood Pressure – currently higher than 180 systolic or 110 diastolic

☐ Recent Surgery – please explain:_____

☐ Pregnancy (Due Date:_____) ☐ Are you expecting twins or multiple births? If so, prenatal classes are not recommended.

☐ None of the above

If you checked any items other than "none of the above", a Medical Clearance form filled out by your doctor is required.

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B. HAVE YOU EVER HAD OR HAVE NOW:

- ☐ Arthritis
- ☐ Back problems
- ☐ Fibromyalgia
- ☐ Diabetes – not using insulin
- ☐ Multiple sclerosis
- ☐ High cholesterol (Level_____)
- ☐ Cigarette smoking ☐ Now ☐ In past
- ☐ Shortness of Breath – please explain: _____
- ☐ Physical Disability – please explain: _____
- ☐ Orthopedic conditions – please explain: _____
- ☐ Other medical problems that may limit your exercise – please explain: _____

_____

List Medications

Name _____ Purpose _____

Name _____ Purpose _____

Name _____ Purpose _____

Name _____ Purpose _____

List Physicians

Physician _____ Phone _____

Physician _____ Phone _____

Physician _____ Phone _____

I verify that this information is correct to the best of my knowledge.

Signature _____

(Please print form and provide handwritten signature)

Please email this form to heidi_torvik@valleymed.org; fax to 425.656.5356; mail to: Heidi Torvik, The Fitness Center, M/S TPC-043, PO Box 50010, Renton, WA 98058-5010; or return it in person at time of sign-up or orientation.