Women Exercising to Live Longer
Application 2021

Today's Date: _____ Age:_____

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip code: _____

Preferred Phone: _____ Alternative Phone: _____

Email address: _____

Please indicate (with a star) your preferred method of contact, cell phone, email or home phone.

Height: _____ Weight: _____ BMI (ok if you don't know): _____

Primary Care Doctor Full Name, Address, Phone and Fax Number:_____

_____

Cardiologist Full Name, Address, Phone and Fax Number: _____

_____

When was your last stress test? _____ Where? _____

Any further info to provide about stress test? _____

1. Please circle how many days per week you will commit to exercise **at** the Beaumont Health Center over the 6-month formal program?

   ◉ 1 ○ 2 ○ 3 ○ 4 ○ 5

2. Considering your work and/or domestic responsibilities, what is the likelihood that you will be able to consistently exercise in the W.E.L.L. program for 6 months, at least 3 days per week?
   - ⊙ a. Poor
   - ○ b. Good
   - ○ c. Very Good
   - ○ d. Excellent

3. How long did it take you to drive here (or the Beaumont Health Center 4949 Coolidge Hwy Royal Oak) today from home or work? _____

4. Please check off time blocks when you are generally available to exercise in the WELL program at the Beaumont Health Center (4949 Coolidge Highway, Royal Oak in-between 14 and 15 mile Rd)

Monday	Tuesday	Wednesday	Thursday	Friday
☐ 6:30am	☐ 6:30am	☐ 6:30am	☐ 6:30am	☐ 6:30am
☐ 7:30am	☐ 7:30am	☐ 7:30am	☐ 7:30am	☐ 7:30am
☐ 8:30am	☐ 8:30am	☐ 8:30am	☐ 8:30am	☐ 8:30am
☐ 9:30am	☐ 9:30am	☐ 9:30am	☐ 9:30am	☐ 9:30am
☐ 10:30am	☐ 10:30am	☐ 10:30am	☐ 10:30am	☐10:30am
☐ 3:30pm	☐ 3:30pm	☐ 3:30pm	☐ 3:30pm	☐ 3:30pm
☐ 5:00pm	☐ 5:00pm	☐ 5:00pm	☐ 5:00pm	☐ 5:00pm

5. Are you planning to be away (i.e. on vacation) for more than two weeks (over the next 6 months)?
   ☐ Yes ☐ No
   If yes, please explain _____

6. Personal Medical History

Please indicate whether you have had any of the following medical problems (with approximate date of diagnosis or illness)

☐ Heart attack – date: _____
☐ Angioplasty/stent – date: _____
☐ Pacemaker and/or defibrillator – date:_____
☐ Atrial Fibrillation (or history of A-fib)
☐ Hypertension (High blood pressure)
On medication? _____
☐ Diabetes or Pre-Diabetic
On medication? _____
☐ Depression/Anxiety
On medication? _____
☐ Cardiac Bypass surgery – date: _____
☐ Heart valve surgery – date:_____
☐ History of Congestive Heart Failure
☐ Stroke/Transient Ischemic Attack – date:_____
☐ Hyperlipidemia (high cholesterol)
On medication? _____
☐ Lung Disease (Asthma, Chronic Obstructive Pulmonary Disease)
On medication? _____
☐ Arrhythmia - Please list: _____

Please provide any additional comments about your health: _____

_____

7. What is your primary motivation to participate in the WELL program?

   _____

   _____

8. What has prevented you from exercising in the past? Check (√) all that apply.

☐ Lack of Motivation ☐ Injury ☐ Can't Afford Gym
☐ Too Tired ☐ Too busy ☐ Low Priority
☐ Chronic Physical Discomfort ☐ Failed exercise attempts
☐ You don't know how to exercise ☐ Weren't seeing changes

9. Joint Pain/ Arthritis/ Musculoskeletal Problems : PLEASE provide details
   ☐ Yes ☐ No
   ☐ Hip ☐ Knee ☐ Back ☐ Feet
   If yes, explain:___
   _____

10. Do you currently use a cane or walker?
    ☐ Yes ☐ No
    If yes, explain why? _____

11. Have you fallen within the last 3 months?
    ☐ Yes ☐ No
    If yes, please explain_____

12. Do you have a history of vertigo or other condition causing balance issues?

☐ Yes ☐ No
If yes, please explain _____

13. Do you have significant visual impairment?
☐ Macular degeneration ☐ Retinopathy ☐ Legal blindness

14. Smoking History

☐ Never smoked ☐ Current smoker - Packs per day ___

☐ Former smoker: Packs per day_____ ____Number of years smoked Quit date: _____

15. Alcohol Use

☐ No (none) ☐ Yes _____# of drinks per week (beer, wine, liquor)

16. Current Stress Level

☐ Low ☐ Moderate ☐ High ☐ Very high

17. Exercise: Do you currently (not used to) follow a regular exercise program? Please provide details!

Activity (walking, biking, Zumba, water aerobics, dancing):_____

_____

Frequency: _____Duration (how many minutes per week): _____

18. Family History Please indicate with a check (X) family members who have had these conditions:

Medical Condition	Mom	Dad	Sister	Brother
Coronary Artery Disease				
Heart Attack				
Stent or Bypass Surgery				
Diabetes Type 1				
Diabetes Type 2				
Hyperlipidemia (high cholesterol)				
Hypertension (high blood pressure)				
Stroke or TIA				
Congestive Heart Failure				

19. Medications – It's OK if you don't have your complete list. Please list what you know!

Medication	Dosage	Number of times per day

Optional Questions:

Socioeconomics:

20. Marital Status: Please indicate with a check (√)

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Decline to answer

Race: _____ Ethnicity: _____ ☐ Decline to answer

Insurance Company Name: _____

21. Employment Status: Please indicate with a check (√) your employment status.

☐ Self-employed ☐ Out of work and looking ☐ Out of work but not looking

☐ Retired ☐ Unable to work ☐ Work Part-time ☐ Work Full-time

☐ Homemaker ☐ Student ☐ Decline to answer

22. Educational Status: Please indicate with a check (√) the highest level of schooling you have completed.

☐ None ☐ Some high school ☐ High school graduate ☐ Some College credit

☐ Associate degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Professional Degree

☐ Doctorate Degree ☐Decline to answer

____ Statin

____ Beta Blocker

____ Ace/ARB

____ Diuretic

____ Calcium Channel Blocker

____ Nitrate

____ Insulin

____ Metformin

____ Anti-Platelet

____ Other:

Please send completed application to wellprogram@beaumont.org.