



Wolfson Wellness Center at Baptist Medical Center Downtown

We are a medical and education-based exercise facility that features state-of-the-art equipment and health education programs to help you meet your healthy lifestyle goals!

Baptist Health Professional Staff

Our professional staff of exercise specialists, nurses, massage therapist, personal trainers and physical therapists are specially trained to meet your needs. The Center meets the American College of Sports Medicine and the American Heart Association guidelines.

Equipment, Services and Facilities

Precor cardiovascular and strength equipment include: treadmills, upright and recumbent bikes, steppers, ellipticals, Power Cage, Smith machine and cable crossover. Massage therapy and personal training are available. We also offer locker rooms with showers.

Memberships

Various memberships are available: employee, individual, corporate and cardiac/pulmonary rehabilitation. New members receive a complimentary one-on-one orientation with an exercise specialist.

Monday–Friday: 5:30am–7:30pm

Saturday: 7:30am–1:00pm

Heart Hospital at Baptist Downtown, 2nd Floor

904.202.9708

wolfsonwellnesscenter@bmcjax.com



Depend On Us For Life.™

e-baptisthealth.com



Member # _____

Start Date _____

WOLFSON WELLNESS CENTER

MEMBER INFORMATION

NAME: _____ BIRTHDATE: ____/____/____ M ____ F ____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: (_____) _____ WORK PHONE #: (_____) _____

CELL PHONE #: (_____) _____ PAGER#: (_____) _____

PERSONAL PHYSICIAN: _____ PHONE NUMBER: _____

PLACE OF EMPLOYMENT: _____

OCCUPATION: _____

EMAIL ADDRESS _____

BAPTIST EMPLOYEES ONLY DEPARTMENT # _____ EMPLOYEE # _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE #: (_____) _____ WORK PHONE #: (_____) _____

CELL PHONE #: (_____) _____ PAGER#: (_____) _____

GENERAL HISTORY

Do you have any of the following? If yes please explain and give dates

Y	N	Any medical complaints?
Y	N	Major illness?
Y	N	Surgery?
Y	N	Allergies to food or medication?
Y	N	Currently taking medication? List

Additional Comments: _____

FAMILY HISTORY

Have any of your blood relatives had any of the following? Please state relation.

Y	N	Angina (Chest Pain)
Y	N	Heart Attack
Y	N	Heart Surgery
Y	N	Coronary Angioplasty / Stent/ Arthrectomy
Y	N	Congestive Heart Failure
Y	N	High Blood Pressure
Y	N	Stroke
Y	N	Aneurysm
Y	N	Pacemaker
Y	N	Diabetes
Y	N	High Cholesterol/Hyperlipidemia

Additional Comments: _____

CARDIOVASCULAR HISTORY

Have you had or do you currently have any of the following?

Y	N	Heart Disease
Y	N	Stroke
Y	N	Heart Murmur/ Extra/ Skipped Beats
Y	N	High Blood Pressure
Y	N	Pain in calves when walking
Y	N	Shortness of Breath ____ At Rest ____ Lying flat ____ Climbing Stairs
Y	N	Angina (Chest Pain)
Y	N	High Cholesterol/Hyperlipidemia
Y	N	Fainting/Dizziness

Additional Comments: _____

OTHER MEDICAL HISTORY

Do you have or have you had any of the following?

Y	N	Arthritis/Bursitis
Y	N	Orthopedic Surgery
Y	N	Bone Fractures
Y	N	Back Pain
Y	N	Glaucoma
Y	N	Seizure Disorder
Y	N	Cataract Surgery
Y	N	Thyroid Disorder
Y	N	Asthma
Y	N	Bronchitis/ Emphysema/ COPD
Y	N	Diabetes Type I or Type II

Additional Comments: _____

