

Name _____ Date: _____

Date of Birth _____ Phone # _____

As a matter of policy, we must have all participants fill out a health risk questionnaire. Common sense is your best guide when you answer these questions. Please read questions carefully.

- YES NO 1. Has your doctor ever said you have a heart or lung problem? _____
- YES NO 2. Do you have any signs or symptoms of heart disease such as chest pain, shortness of breath, unexplained dizziness, or lightheadedness? _____
- YES NO 3. Do you have diabetes? _____
- YES NO 4. Are you pregnant? _____
- YES NO 5. Are there any bone, back, or joint problems or recent surgeries that could be made worse by a change in your activity level? ie. arthritis, osteoporosis, disc disease, rotator cuff, etc. explain: _____
- YES NO 6. Are you being treated by a doctor for any other illness that may be affected by an exercise program? ie. cancer, kidney disease, _____

If you answered "yes" to any of the questions 1-6, a physician clearance form is required for program participation.

- YES NO 7. Family History: Has your mom, dad, brother or sister been diagnosed with heart disease before age 55 for a male and age 65 for a female.
- YES NO 8. High Blood Pressure: Do you have high blood pressure or are you taking medications to control your blood pressure?
- YES NO 9. High Blood Cholesterol: Is your total cholesterol over 200 and/or LDL over 130 or do you not know your cholesterol numbers.
- YES NO 10. Smoker: Do you currently smoke or did you quit and it has not been over 6 months yet?
- YES NO 11. Inactivity: Do you engage in less than 90 minutes of exercise per week?
- YES NO 12. Age: Are you a male over the age of 45, or a female over the age of 55?

If you answered "yes" to two or more of the questions 7-12, a physician clearance form is required for program participation.

Physician Name (please print): _____ Phone: _____ Fax: _____

I hereby certify that the above information is true and correct to the best of my knowledge.

I authorize Capital Region Medical Center (CRMC) to contact my physician as stated above, for consent for me to participate in an exercise program at Capital Region Healthplex.

Member Signature: _____ Witness (HP Staff): _____

Reviewed by: _____

PHYSICIAN CLEARANCE FORM

Confidential Fax Date: _____

List Restrictions: _____

"Based upon my medical knowledge of this patient and subject to any restrictions listed above, I am unaware of any condition that would preclude he/she from participating in an exercise program."

Physician Signature: X _____ Date: _____

If you have any questions or concerns or would like to inquire about other services that we offer, please contact us at 573-632-5634. Return fax: 573-632-5990 Mailing Address: P.O. Box 1128, Jefferson City, MO 65102-1128