personalbest

Pre-Exercise Medical Clearance Form

Dr. _____

Your patient is interested in undertaking a health and fitness program with Personal Best. An exercise program will be tailored to suit the health and fitness needs of your patient following an initial evaluation / consultation. The exercise program may consist of moderate to vigorous aerobic exercise (walking, cycling, swimming, running) and/or strength training exercises as appropriate including use of body weight, fitness balls, elastic resistant bands, free weights or pin-loaded equipment.

Personal Best is a health and fitness consultancy providing professional health and fitness services to individuals and organisations. Personal Best consultants are all qualified personal trainers with extensive experience in personal health and fitness for the general population.

It would be appreciated if you could complete the following form and provide approval for this patient to undertake a graduated health and fitness program. Please complete the form and return it to the patient. Please circle/ tick the appropriate response and complete additional details where appropriate.

Patient's Name: _____

1. Medical History

a) Does the patient have any form of heart disease? YES NO

If YES, please specify: _____

If NO, has the patient ever had any of the following:

i) chest pain YES NO

ii) breathlessness or upper body discomfort upon hurrying or with any other form of exercise YES NO

iii) abnormal ECG YES NO

iv) any major heart or cardiovascular investigations YES NO

If Yes, please specify: _____

b) Has the patient ever had:

i) high blood pressure ? YES NO Present ___ Past but not now ___

ii) diabetes ? YES NO Present ___ Past but not now ___

iii) high cholesterol ? YES NO Present ___ Past but not now ___

iv) any haematological or immune system disorders which may affect their ability to participate ? YES NO Present ___ Past but not now ___

v) any epilepsy or other neurological disorder? YES NO

Present ___ Past but not now ___

vi) any other major illness or disease that may limit their ability to participate? (e.g asthma, arthritis, back pain) YES NO

Present ___ Past but not now ___

2. Medications

Is the patient currently or recently (within the last 12 months) taking / taken:

a)	Blood pressure medication	YES NO
b)	Diuretics	YES NO
c)	Cardiac medications	YES NO
d)	Gout medication	YES NO
e)	Arthritis / anti-inflammatory	YES NO
f)	Asthma medication	YES NO
g)	Other medication	YES NO

If YES, please indicate the following

Medication Name	Reason for Medication	Dosage	Duration on medication	Possible relevant side effects

Medical Clearance

____ I feel that there are NO medical contra-indications to my patient undergoing a graduated exercise program.

____ I feel that my patient is NOT able to participate in a graduated exercise program for the following reasons: _____

_____

_____

Medical Practitioner's Signature: _____ Date: ____/____/____

Medical Practitioner's Name: _____

Address: _____

Telephone: (_____) _____