YMCA Gold Fit

MEDICAL CLEARANCE
to participate in graded exercise

Full Name: _____ Today's Date:_____
Street Address: _____Suburb/city: _____Post Code:_____
Date of Birth: _____ Age: _____ M / F
Phone: Home _____ Mobile _____ Email: _____
Emergency Name :(relationship) _____Phone: _____
Family GP: _____ Phone: _____
Address: _____
_____
Specialist: _____ Phone: _____
Address: _____

MEDICAL HISTORY

TO BE COMPLETED BY DOCTOR OR NURSE

Cardiovascular Disease

- ☐ MI: Date _____ Details _____
- ☐ CABG: Date _____ Details _____
- ☐ Angioplasty/Stent: Date _____
- ☐ Heart failure: Details _____
- ☐ Arrhythmia Type: _____
- ☐ Angina Stable/Unstable: _____
- ☐ Pacemaker: Details _____
- ☐ Hypertension: _____
- ☐ Cholesterol level: TOTAL$_{(\geq 5.18)}$_____ HDL$_{(<1.04)}$____ LDL$_{(\geq 3.37)}$____
  Triglycerides$_{(\geq 1.7)}$_____
  TG/HDL$_{(\geq 4.0)}$_____

MEDICATIONS

- ☐ Beta Blockers: _____ _____
- ☐ ACE inhibitors: _____ _____
- ☐ Diuretics: _____ _____
- ☐ Aspirin/Warfarin
- ☐ Nitrates spray/tablets:_____
- ☐ Statins: _____
- ☐ Other:_____

Metabolic Disease

- ☐ Diabetes: Type ____ Blood Glucose$_{(\geq 5.5)}$:_____HbA1c$_{(\geq 40)}$_____
- ☐ Other:_____

- ☐ Oral Hypoglycemics:_____ _____
- ☐ Other:_____

Respiratory Dysfunction:

- ☐ Smoking: YES / NO

- ☐ Inhalers_____ _

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☐ Asthma _____ ☐ COPD _____	☐ Corticoids_____ ☐ Other:_____
Neurological Impairments: ☐ Stroke/Parkinson/MS/ Epilepsy/ others_____	☐ _____ ☐ _____
Musculoskeletal Impairments: ☐ Arthritis:_____ _ ☐ Hip/Knee Replacement or joint condition: _____ ☐ Back/Shoulder injury: _____ ☐ Hernia of any kind: _____ ☐ Gout: _____ ☐ Serious injury/illness: _____	☐ _____ ☐ _____ ☐ _____ ☐ _____

☐ Other health conditions not listed above: _____
_____
_____
_____

☐ Other medications not listed above: _____
_____
_____
_____

☐ Allergies: _____

Please include a safe exercise heart rate if known: _____ bpm.

Please list ANY HEALTH PROBLEM that may affect your patient doing graded exercise:

_____
_____
_____

Evaluation of patient's current fitness levels: (circle)

Very low Low Moderate Good Very Good Excellent

NAME of DOCTOR/NURSE: _____

SIGNED: _____

DATE: _____