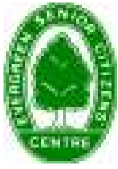


MEDICAL CLEARANCE

Dear Doctor,
Your Patient is interested in participating in a regular exercise program at the Evergreen Centre, 45 Talbot Ave, Balwyn. Please complete the following information to assist our Fitness Instructors in performing a pre-exercise health and fitness consultation and design a suitable exercise program. Please detail all conditions, acute & chronic, which may impact upon this patient in relation to an exercise program. All information will be treated as strictly confidential by our Fitness Instructors.

Thank you for your co-operation.

Gillian Roebuck, 9836 9681

Patient Name	Date of Birth

Medical conditions

CURRENT MEDICAL CONDITIONS	DATE OF ONSET

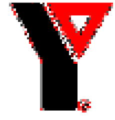
PAST/RESOLVED MEDICAL PROBLEMS Eg. Frozen shoulder, orthopaedic surgery, please indicate past injuries	DATE

Patient Medication and Effects

NAME	CONDITION	EFFECTS OF THIS MEDICATION IN RELATION TO EXERCISE IF ANY

HEIGHT	WEIGHT	BMI	BLOOD PRESSURE	RESTING PR	RHYTHM
			Systolic / Diastolic /		

MEDICAL CLEARANCE



Current level of physical activity : eg slow/brisk walk, duration & frequency

____

____

Any contraindication to weight training: YES / NO
If yes please detail below

____

____

Any contraindication to aerobic exercise: YES / NO
If yes please detail below

____

____

Any specific exercise not recommended: YES / NO
If yes please detail below

____

____

When would you like to review this patient? (please circle)

N/A 6 Weeks 3 Months 6 Months 1 Year 18months

Physician Name & Clinic Address	**Phone No.**	**Physician Signature**
	Fax No.	

Optional Feedback:

1. Time taken to complete clearance form **……mins**
2. Do you have any comments to make about this clearance form?

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