**FITNESS AND MEDICAL QUESTIONNAIRE**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please read the questions carefully and check the Yes or No box for each.

Yes No

|  |  |  |
| --- | --- | --- |
|  |  | Has your doctor ever told you that you have heart or lung problems? |
|  |  | Have you frequently felt any chest discomfort or pain? |
|  |  | Do you generally experience dizziness and/or faintness? |
|  |  | Has your doctor ever told you that you have high blood pressure? |
|  |  | Do you take medication to lower your blood pressure? |
|  |  | Are you aware of any bone, back or joint problems that could be aggravated with exercise? (e.g. arthritis) |
|  |  | Have you ever had an episode of exercise-induced asthma, severe wheezing, coughing, or severe shortness of breath brought on by exercise? |
|  |  | Have you ever been told by your doctor that you have diabetes? |
|  |  | Are you older than age 65 and not involved in regular exercise? |
|  |  | Is there any reason why you should not engage in exercise? (e.g., surgery during the past six months)  Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*I hereby certify that the above information is true and correct to the best of my knowledge. I understand that if I answered “Yes” to any of the questions listed above, medical clearance from my physician is required. In such event, I hereby authorize the Logan County Rehabilitation and Wellness Center at Logan County Hospital to contact my provider in order to obtain medical clearance, which will allow me to participate in exercise and/or a fitness program.*

Applicant Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Print Providers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider’s Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**MEDICAL CLEARANCE FORM**

This is only required for individuals answering “Yes: to any of the above questions. I hereby certify that, to the best of my knowledge, the above stated person has no contraindication to participation in an exercise and fitness program.

Provider’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Limitations (if any)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_