



**Part A** Personal Information (Please complete Part A and B before your appointment with your Health care provider)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ GENDER: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Post: \_\_\_\_\_

Personal Trainer: \_\_\_\_\_ PT Contact: \_\_\_\_\_

**Part B** Pre Exercise Health Checklist

**PRE EXERCISE QUESTION:**

Which question/s did you answer YES to on the Pre Ex?

- Diabetes
- Heart Condition
- Asthma
- Bone / Joint Problems
- High / low Blood Pressure
- High Cholesterol
- Epilepsy
- Sports injury
- Cardiovascular Disease
- Dizziness
- Other Problems:

**PHYSICAL ACTIVITY INTENTIONS:**

What physical activity do you intend to do?

.....

.....

.....

.....

.....

.....

**RISK FACTORS FOR CARDIOVASCULAR DISEASE:**

Which, if any, of the following applies to you?

1. Less than 30minutes of moderate physical activity most days of the week.
2. Currently a smoker (tobacco smoking 1 or more times per week)
3. High Blood pressure reported by physician after repeated measurements.
4. High cholesterol level reported by physician.
5. Excessive accumulation of fat around waist.
6. Family history of heart disease.

# PARmed-X

## Physical Activity Readiness Medical Examination

### Part C Contraindications To Exercise *(To be completed by your health care provider)*

#### CONDITIONS LIMITING PHYSICAL ACTIVITY

- Cardiovascular
  - Musculoskeletal
  - Respiratory
  - Abdominal
  - Other
- 
- 

#### RELATIVE CONTRAINDICATIONS:

Based on a current review of health status, I recommend:

- 1. No Physical activity
- 2. Only a medically-supervised exercise program until further medical clearance.
- 3. Progressive physical activity: 
  - with avoidance of: .....
  - with inclusion of: .....
  - under medical supervision
- 4. Unrestricted physical activity - start slowly and build up gradually

## PARmed-X

### INSTRUCTIONS:

1. The patient should fill out the section on PATIENT INFORMATION (Part A) and the PRE-EXERCISE HEALTH CHECKLIST (PART B) and give the form to their Doctor.
2. The health care provider should check the information provided by the patient for accuracy and fill out Page 2 on CONTRAINDICATIONS (Part C) based on current medical information.
3. The HEALTH EVALUATION FORM should be completed, signed by the health care provider, and given by the patient to their fitness professional.



**HEALTH EVALUATION FORM**

( To be completed and given to the Better Shape Fitness Pty Ltd after obtaining medical clearance to exercise )

I, \_\_\_\_\_ ( please print patient's name ), have discussed my plans to participate in physical activity with my health care provider.

 \_\_\_\_\_

Patient Signature

Date: \_\_\_\_\_

**RELATIVE CONTRAINDICATIONS:**

Based on a current review of health status, I recommend:

NAME OF HEALTH CARE PROVIDER

1. No Physical activity

ADDRESS

2. Only a medically-supervised exercise program until further medical clearance

PHONE

3. Progressive physical activity:

with avoidance of: \_\_\_\_\_

with inclusion of: \_\_\_\_\_

 \_\_\_\_\_

HEALTH CARE PROVIDER'S SIGNATURE

under medical supervision

4. Unrestricted physical activity - start slowly and build up gradually



References:

Arraix, G.A., Wigle, D.T., Mao, Y. (1992). Risk Assessment of Physical Activity and Physical Fitness in the Canada Health Survey Follow- Up Study.45:4 419-428.

Mottola, M., Wolfe, L.A. (1994). Active Living and Pregnancy, In:

A. Quinney, L. Gauvin, T. Wall (eds.), Proceedings of the International Conference on Physical  
Champaign, IL: Human Kinetics.

BLANK