The Ohio State University
Exercise Testing Medical History

1. GENERAL INFORMATION Please fill ALL blanks.

Name _____ Date _____ Age _____ Sex _____

DOB _____ Employee ID # _____

Height _____ Weight _____ Email _____

Home Phone _____ Business Phone _____

In case of emergency, contact:

Name _____ Phone _____ Relationship _____

2. MEDICAL-SURGICAL HISTORY Check (x) if answer is yes.

Have you ever had (if so, indicate date):

( ) Rheumatic heart disease
( ) Heart Murmur
( ) High Blood Pressure
( ) High Cholesterol
( ) Gout
( ) Varicose Veins
( ) Lung Disease
( ) Injuries to back, etc.
( ) Epilepsy
( ) Diabetes
( ) Asthma
( ) Heart Attack/Heart Surgery
( ) Other Operations
( ) Kidney Disease
( ) Stomach Ulcers
( ) Arthritis
( ) Hospitalizations
( ) Cardiac Catheterization

( ) Accidents
( ) Chest pains
( ) Tightness in chest particularly during exercise
( ) Shortness of breath
( ) Chest pain
( ) Heart palpitations
( ) A stress test or graded exercise test
( ) Excessive cough
( ) Back pain
( ) Swollen, stiff or painful joints
( ) Difficulty sleeping
( ) Fatigue
( ) Calf pain or cramps with exercise
( ) Nervousness
( ) Other problems
( ) Are you under the care of a specialist?
*** Important info: please list cholesterol, triglycerides, and blood glucose below**

Please explain any positive answers:

_____

_____

MEDICATIONS: Please list those you are presently taking.

DRUG DOSE REASON FOR TAKING

_____

_____

_____

3. ADDITIONAL RISK FACTOR EVALUATION ITEMS:

Please list any first degree male or female relatives that have had a heart attack/stroke and the age at which it occurred. _____

Do you smoke or have you quit in the last 6 months? Y ( ) N ( )

If you smoke, how much per day? _____

Please circle what best describes you on a daily basis:
a) rarely tense or anxious
b) calmer than average – feel tense about 3x/wk
c) about average – feel tense 2-3x/day
d) quite tense – usually rushed
e) extremely tense – take a tranquilizer

4. PRESENT REGULAR EXERCISE:

Type of exercise: _____ Type of exercise: _____ Type of exercise: _____

Minutes/session: _____ Minutes/session: _____ Minutes/session: _____

Days/week: _____ Days/week: _____ Days/week: _____

5. GOALS FOR EXERCISE: Indicate what you would like to accomplish through your exercise training program. This will assist us in evaluating your present program.

_____

_____

_____

(Revised 7/10)

GRADED EXERCISE TEST

CLEARANCE OF PERSONAL PHYSICIAN

1. _____ is interested in participation in the Graded Exercise Test which we provide. Testing procedures include a symptom limited graded exercise test and maximal oxygen consumption. All testing policy and procedures follow the recommendations of the American College of Sports Medicine.

2. Please mark the option that describes the suitability of your patient to participate in the evaluation.

   _____ I know of no reason why he/she may not be tested.

   _____ I feel he/she may be evaluated, but urge caution due to:

   _____

   _____

   _____

   _____ This patient's present history contraindicates fitness evaluation.

_____ _____
Physician's signature Date

_____
(print name)

Physician's Address: _____

_____

_____

Return this form to: Emily Martini
A52 PAES Building
305 W. 17th Ave
Columbus, Ohio 43210
Phone: 614-292-2255
Fax: 614-688-3432