The Ohio State University
Exercise Testing Medical History

1. GENERAL INFORMATION Please fill in ALL blanks.

Name: _____ Date: _____ Sex: _____

DOB: _____ Height: _____ Weight: _____

Email: _____ Cell 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 list recent hospitalizations (Women: do not list normal pregnancies).

_____

_____

_____

4. CURRENT REGULAR EXERCISE:

Type of exercise: _____ Type of exercise: _____

Minutes/session: _____ Minutes/session: _____

Days/week: _____ Days/week: _____

Type of exercise: _____ Type of exercise: _____

Minutes/session: _____ Minutes/session: _____

Days/week: _____ Days/week: _____

GRADED EXERCISE TEST (VO_2max)

PHYSICIAN CLEARANCE FORM

1. _____ is interested in participating in a Graded Exercise Test (VO_2max) which we provide. Testing procedures include a symptom limited graded exercise test, maximal oxygen consumption, and ECG. 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 this test.

_____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 Name (please print) Date

_____

Physician's Signature

Physician's Address: _____

_____

_____

Return this form to:

Maggie Roe, MS, ACSM-CEP
Exercise Science Lab Manager
A042 PAES Building
305 Annie & John Glenn Ave.
Columbus, Ohio 43210
Phone: 614-247-0287
Fax: 614-688-3432