



**Diagnosed Disease:**

- Cardiovascular (CVD)
- Peripheral vascular
- Cerebrovascular disease
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Interstitial lung disease
- Cystic fibrosis
- Diabetes mellitus (type I or II)
- Thyroid disorder
- Renal or liver disease
- Eating disorder

**Other Health Issues:**

- You are pregnant
- You have concerns about the safety of exercise
- You have musculoskeletal problems. Please explain: \_\_\_\_\_
- You have allergies (i.e. food, drug). Please explain: \_\_\_\_\_
- You take prescription medication(s)

**Medication name** \_\_\_\_\_ :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<p style="text-align: center;"><b>Risk Factor Analysis (Official use only)</b></p> <p>Number of risk factors _____</p> <p>Number of signs and symptoms _____</p> <p><input type="checkbox"/> Low</p> <p><input type="checkbox"/> Moderate</p> <p><input type="checkbox"/> High</p> <p><input type="checkbox"/> <b>Medical Clearance is recommended</b></p>
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