



# Valley Medical Fitness Center

## Medical Clearance Request Form

To Be Completed by the Physician

Physician: \_\_\_\_\_

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

Fax No: \_\_\_\_\_ Phone  
No: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Birth

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

Daytime Phone: \_\_\_\_\_

Your patient has requested to participate/return to participation in the following program(s) at Valley Fitness Club:

<input type="checkbox"/> Supervised Water Exercise	<input type="checkbox"/> Unsupervised Exercise
<input type="checkbox"/> Supervised Exercise	<input type="checkbox"/> Mind/Body Classes (Yoga, Tai Chi, Qi Gong, Pilates, etc.)

Due to their medical history it is necessary that we request a medical clearance. Contraindications for membership are as follows:

- Unstable orthopedic condition ..      ➤ Uncontrolled diabetes
- Coronary, Pulmonary, or Metabolic conditions including, but not limited to:

**Symptomatic arrhythmias**  
**Hypertrophic cardiomyopathy**

**Recent embolism**

Symptomatic aortic stenosis  
hypertension

Resting BP over 180/110

Pulmonary

Unstable angina  
Symptomatic congestive heart failure

Active thrombophlebitis

### Medical Screening Questions:

1. Has the patient had an MI, CABG, angina, angioplasty, atherectomy, or symptoms of coronary artery disease?

Yes \_\_\_\_\_ No \_\_\_\_\_ Date: \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Has the patient had a history of Pulmonary, Metabolic, or Vascular Disease?

Yes \_\_\_\_\_ No \_\_\_\_\_ Date: \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***If yes to either question 1 or 2, a treadmill stress test done within the last 12 months is required prior to enrollment at the Fitness Center. Please send a copy of recent treadmill results.***

\_\_\_\_\_ Treadmill waived. I do not wish to perform a maximum treadmill test on this patient although he/she falls within the American College of Sports Medicine guidelines for testing prior to exercise.

Date of last treadmill: \_\_\_\_\_ (Please attach a copy)

Any Abnormalities? \_\_\_\_\_  
\_\_\_\_\_

3. Has the patient recently undergone any surgery? Yes \_\_\_\_\_ No \_\_\_\_\_ Date: \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Does the patient have any other medical conditions which may limit exercise? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Exercise Recommendations:**

\_\_\_\_\_ No Restrictions

\_\_\_\_\_ Restricted from the following activities:

_____ Treadmill	_____ Weight training	_____ Steam room
_____ Stairmaster	_____ Gym aerobics	_____ Swimming

\_\_\_\_\_ Bike                      \_\_\_\_\_ Water aerobics                      \_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_ Rowing machine                      \_\_\_\_\_ Recreational sports

**Physician Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

(Please return to Valley Fitness Center at 400 S. 43rd St., PO Box 50010, Renton, WA 98058 or Fax to 425-656-5356)