Medical/Exercise Assessment for Older Adults

THIS FORM MUST BE UPDATED AT LEAST ONCE A YEAR

Name: _____Phone: (Home) _____ (Cell) _____

Street address: _____City: _____ Zip: _____

Emergency contact: _____Phone: (Home) _____ (Cell) _____

Date of Birth: _____ Age: _____

PART 1- TO BE FILLED OUT BY PARTICIPANT

A. Health History

1. Weight _____Height _____Blood Pressure _____ Pulse _____

B. Statement of Present Health

1. Your statement of present health: ☐ Excellent ☐ Good
2. ☐ Fair/Poor (Please Explain) _____

2. Please list hospitalization AND surgical procedures, reasons, and dates: _____

_____

3. Do you take non-prescription drugs routinely? ☐ No ☐ Yes (Please list) _____

_____

4. Do you take prescription drugs routinely? ☐ No ☐ Yes (Please List) _____

_____

5. Do you suffer from any of the following: (check all that apply)

- ☐ Allergies (food, seasonal, medicine)
- ☐ Asthma
- ☐ Broken Bones
- ☐ Diabetes
- ☐ Ear, nose or throat trouble
- ☐ Eye Trouble
- ☐ Gout
- ☐ Hearing Loss
- ☐ High or low blood pressure
- ☐ Loss of memory
- ☐ Pain or pressure on chest
- ☐ Tuberculosis
- ☐ Balance Problems
- ☐ Cramps in your legs
- ☐ Difficulty with hearing
- ☐ Emphysema
- ☐ Frequent or severe headaches
- ☐ Hardening of the arteries
- ☐ Heart Trouble
- ☐ Joint Replacement
- ☐ Osteoarthritis
- ☐ Stroke
- ☐ Cancer (type) _____
- ☐ Anemia/blood disorder
- ☐ Bowel/bladder problems
- ☐ Depression
- ☐ Dizziness/fainting spells
- ☐ Epilepsy
- ☐ Gallbladder Trouble
- ☐ Hernia
- ☐ Hepatitis
- ☐ Limit of joint motion
- ☐ Osteoporosis
- ☐ Swollen or painful joints

C. OTHER

Please provide any relevant details or additional conditions: _____

_____

PART II- TO BE FILLED OUT BY PHYSICIAN

*** NOTE TO PHYSICIAN- This program is not a rehab program, nor does it serve as a substitute for medical treatment or therapy. Participants must be able to perform exercises independently.**

PHYSICIAN RECOMMENDATION(S)

___I recommend that my patient participate in a fitness program.

___ My patient can participate in a fitness program, BUT urge caution because:

_____

_____

___ I recommend that my patient NOT participate in a fitness program.

PHYSICIAN_____ **PHYSICIAN SIGNATURE:_____**	**DATE OF PATIENT'S EXAM:** **_____**
ADDRESS: _____ **_____**	**PHONE NUMBER:** **_____**

<u>PART III - PATIENT'S CONSENT AND RELEASE</u>

<u>PLEASE INITIAL</u>

_____ I understand the program is not a therapy program, nor should it be a substitute for medical treatment.

_____ I am aware that I am required to seek consultation from my physician about whether I can safely participate in an Exercise program and whether there are any precautions or limitations to my participation.

_____ I agree to see my physician for medical care and agree to have a physical evaluation performed at least once a year.

_____ Release: I hereby release the above information to the RoseHouse Health & Wellness Center and/or Greenhouse.