

Physician Consent Form - UNCG-HOPE

Patient Name: _____

Age: _____

Does this patient have or have a history of any of the following medical conditions? Please explain any "yes" answer.

Risk Factors:

- _____ Hypertension
- _____ Hyperlipidemia: ___HDL___LDL___total___triglycerides
- _____ Diabetes or impaired fasting glucose
- _____ Current Tobacco Use
- _____ Obesity
- _____ Inactive/Sedentary Lifestyle
- _____ Family history

Pulmonary Conditions:

- _____ Chronic Lung Disease
- _____ Asthma

Mental/Emotional Disorders:

- _____ Depression
- _____ Anxiety/panic attacks
- _____ Other (please explain)

Cardiovascular Conditions:

- _____ CAD
- _____ MI
- _____ Ventricular arrhythmia
- _____ Atrial fibrillation/flutter
- _____ Other dysrhythmia
- _____ PTCA/Stent/Athrectomy
- _____ CABG
- _____ Congestive Heart Failure
- _____ Other cardiac procedures:
- _____ Stroke or TIA
- _____ Peripheral Vascular Disease

Other Medical Conditions:

- _____ History of falls
- _____ Use of cane/wheelchair/walker
- _____ Joint replacement
- _____ Osteoporosis or osteopenia
- _____ Cancer
- _____ Arthritis
- _____ Surgical Procedures: _____
- _____ Other chronic conditions: _____
- _____ Anemia
- _____ Hearing loss
- _____ Uncorrected vision problems
- _____ Phlebitis or emboli
- _____ Infectious disease:

Current Medications: (please list medication and reason for taking)

_____	_____
_____	_____
_____	_____
_____	_____

Do you know of any reason that this person should not perform exercise? Yes____ No____
If yes, please explain.

Additional comments or explanations of above conditions: _____

I believe that it is safe for _____ to participate in the UNCG HOPE program.

Signed: _____ Date: _____

Printed: _____

Please attach a copy of any pertinent information that may be helpful in designing a safe exercise program for your patient (GXT results, etc).