Hackensack Meridian *Health*
Mountainside Medical Center

CARDIOVASCULAR FITNESS CENTER
COMMUNITY PROGRAM

The Community Exercise Program (located on the 1st floor of Mountainside Medical Center) is a medically supervised program for individuals who wish to learn how to exercise properly, reduce or prevent cardiovascular risk factors, and manage their weight. A personalized program is developed for each participant.

Requirements

- Health History Questionnaire completed and returned which will determine the degree of medical clearance required.
- An evaluation/consultation by our staff.
- Stress test if you are over 40 years of age for males, over 50 years of age for females, or if indicated by your medical history unless otherwise indicated by your Private Physician.

Hours

Monday, Wednesday - 12:00 p.m. to 7:00 p.m.
Tuesday - 6:00 a.m.– 2:00 p.m.
Thursday - 6:00 a.m.– 2:00 p.m.
Friday - 12:00 p.m. to 2:00 p.m.

Fee Schedule

Monthly Fee - $36.00

The Fee is payable to the Cashier in the Front Lobby after the 10th of each month.

If you have any questions regarding any of the information, please feel free to call us at 973-429-6199.

CARDIOVASCULAR FITNESS CENTER
973-429-6199 fax 973-680-7741
COMMUNITY EXERCISE PROGRAM CLEARANCE FORM

Dear Doctor:

Your patient,_____, has applied for participation in a supervised exercise program for individuals who wish to lose weight, learn to exercise properly, and reduce cardiovascular risk. This program is conducted at HackensackUMC Mountainside's Cardiovascular Fitness Center. Prior to participation we require a medical clearance from your office.

Description of the Program:

Based on your guidelines, the stress test and further fitness evaluation by the center's staff, an individualized exercise program will be developed for the participant. The program will include 3-5 sessions per week. The exercise session includes aerobic, strength, and flexibility exercise based on Heart Rate and Perceived Exertion Scale.

_____ **NO STRESS TEST REQUIRED TO EXERCISE**

Medical Recommendations:

Are there any limitations to weight training?

Yes: _____ No: _____ Explain : _____

Do you recommend aerobic conditioning? Yes: _____ No: _____

Special Recommendations or Guidelines: _____

_____

I recommend the above named patient for participation in the Exercise Program at Mountainside Medical Center.

_____
Physician Name

_____
Address

_____ _____
Phone Number Physician Signature

HackensackUMC Mountainside

Name: _____ Age: _____ Date:_____

Diagnosis: _____

_____

Medications:_____

_____

Risk Factors: HTN ____ Obesity _____ Diabetes _____ Stress____

Sedentary Lifestyle ____ Hyperlipidemia ____ Family History_____

Smoking ____

Physical:
Height _____ Weight_____ Pulse_____ BP_____

Heart: _____
Lungs: _____

Extremities: Edema _____

Laboratory: (Fill in or enclose reports) Lytes (If Indicated)
RBC _____ WBC_____ HB_____ HCT_____ NA _____ K_____ CL_____

Chol._____ Trig._____ HDL _____ LDL_____ Chol/HDL=_____ LDL/HDL_____

EKG - Send Copy

Allergies: _____

Special Recommendations or Guidelines: _____

_____

_____

2013 Reviewed 1995, 1996, 9/98, 5/01, 9/04, 7/07,2/10, 1/13

HackensackUMC Mountainside

FOR PATIENT COMPLETION:
CARDIOVASCULAR FITNESS CENTER HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date:_____
Last First

Address: _____ Age:_____

Date of Birth: _____ Phone: _____

Sex: _____ Height: _____ Weight: _____

Occupation: _____ e-mail: _____

Physician's Name: _____ Address: _____

Phone Number: _____

Date of Last Physical: _____

Do You Smoke? Yes_____ No_____

Women: Are you pregnant at this time? Yes_ No

Are you currently under the care of a physician for any reason? Yes ____ No ____
Explain and list all known medical diagnosis:

_____

_____

List all medications (prescription or over the counter):

_____

_____

List any allergies: _____

Have you recently been hospitalized? Yes _____ No_____

Explain: _____

List any surgeries you have had: _____

_____

Do you exercise regularly? Yes: _____ No: _____ How Often? _____

Have you ever had a stress test? Yes _____ No_____

When and where? _____

Have any members of your immediate family been diagnosed with Heart Disease? Yes _____ No _____ Explain:_____
_____

Any History Of:	Yes	No
Chest Pain, Pressure, Tightness	_____	_____
Shortness of Breath	_____	____
Palpitation or Pounding of Heart	_____	____
Dizziness, Lightheadedness	_____	_____
Heart Murmur	_____	_____
Heart Disease	_____	____
Heart Attack	_____	____
High Blood Pressure	_____	____
High Cholesterol	_____	____
Diabetes	_____	____
Anemia	_____	____
Seizures	_____	____
Asthma	_____	____
Emphysema	_____	____
Arthritis	_____	____
Hernia	_____	____

Orthopedic Problems: _____ ____

Please elaborate on any Yes answers: _____

_____

What are your goals for this exercise program?

_____

_____

2013 Reviewed 1995,'97,'98,'01,'04,'07,'10, '13