



**CARDIOVASCULAR FITNESS CENTER
COMMUNITY PROGRAM**

The Community Exercise Program (located on the 1st floor of Mountainside Hospital) 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.– 7:00 p.m.**

Friday - **12:00 p.m. to 2:00 p.m.**

Fee Schedule

Monthly Fee - \$34.00

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.

**THE MOUNTAINSIDE HOSPITAL
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 The Mountainside Hospital'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 The Mountainside Hospital.

Physician Name

Address

Phone Number

Physician Signature

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 : _____

1993

Reviewed 1995, 1996, 9/98, 5/01, 9/04, Revised 7/07, 2/10

THE MOUNTAINSIDE HOSPITAL
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, Light headedness	_____	_____
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?
