



**MIHE MEDICAL CLEARANCE FORM**  
(To be completed by physician)

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Ins. Contract #: \_\_\_\_\_

Referring Physician \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

**The following information is required prior to meeting with our exercise staff**

- Complete history and physical examination (within last 12 months)
- A1c/FBS (diabetic or if elevated)
- List current medications and dosages below:

Medication	Dosage	Frequency

<b>Pertinent medical history (PLEASE check ALL that apply)*</b>		
Diabetes Mellitus TYPE 1 <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled  TYPE 2 <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	Hypertension <input type="checkbox"/> Benign <input type="checkbox"/> Malignant <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertriglyceridemia <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Renal Disease <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> COPD <input type="checkbox"/> Asthma	<input type="checkbox"/> Morbid Obesity <input type="checkbox"/> Obesity <input type="checkbox"/> Chronic Low Back Pain <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Inappropriate Diet/Eating Habit <input type="checkbox"/> Lack of physical exercise <input type="checkbox"/> GERD <input type="checkbox"/> Depression <input type="checkbox"/> Other (please specify): _____

- NO, the patient named above is **NOT** cleared to participate in the exercise program.
- YES, the patient named above is cleared to participate in the exercise program.

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Send Medical Information to:  
4986 Adams Rd., Suite E, Rochester, MI 48306  
Tel: 248- 475-4880 • Fax: 248-475-4881 • [www.miteam.org](http://www.miteam.org)