



## Lakeshore Sports Physical Therapy

### PHYSICAL ACTIVITY READINESS MEDICAL EXAMINATION

Welcome! Thank you for selecting us for exercise guidance during this special time in your life! We will strive to provide you with the best possible service. To assist us in meeting your needs, please complete these forms with the assistance of your obstetrician. The Physical Activity Readiness Medical Examination is a guideline for health screening prior to participation in prenatal exercise. If you have any questions or need assistance, we would be happy to help.

Healthy women with uncomplicated pregnancies can integrate physical activity into their daily living and can participate without significant risks either to themselves or to their unborn child. Postulated benefits of such programs include improved aerobic and muscular fitness, promotion of appropriate weight gain and facilitation of labor. Regular exercise may also help prevent gestational glucose intolerance and pregnancy-induced hypertension.

The safety of prenatal exercise programs depends on adequate levels of maternal-fetal physiological reserve. The Physical Activity Readiness Medical Examination for Pregnancy is a convenient checklist and prescription for use by physicians to evaluate pregnant patients who want to enter a prenatal fitness program and for ongoing medical surveillance of exercising pregnant patients.

Please note the following instructions:

1. The patient/client should fill out the section on PATIENT/CLIENT INFORMATION and the PRE-EXERCISE HEALTH CHECKLIST (Parts 1, 2, 3, & 4 on pages 1 & 2) and give the form to the physician monitoring her pregnancy.
2. The physician should check the information provided by the patient for accuracy and fill out SECTION C on CONTRAINDICATIONS (page 2) based on current medical information
3. If no exercise contraindications exist, the HEALTH EVALUATION STATEMENT (page 3) should be completed, signed by the physician, and returned to Lakeshore Sports Physical Therapy by the patient/client.

**NOTE:** Sections A and B should be completed by the patient/client prior to the appointment with the physician.

#### A Patient/Client Information

Last Name: _____	First Name: _____	MI: _____
Home Phone: _____	Work Phone: _____	
Date of Birth: _____	Where do you prefer to receive calls? <input type="checkbox"/> Home <input type="checkbox"/> Work	
Address: _____	Apt. #: _____	
City: _____	State: _____	Zip: _____
In the event of an emergency, whom should we contact?		
Name: _____	Relationship: _____	
Daytime Phone: _____	Evening Phone: _____	

#### B Pre-exercise Health Checklist

##### Part 1: General Health Status

Number of previous pregnancies: \_\_\_\_\_

In the past, have you experienced:

1. Miscarriage in an earlier pregnancy? ☐ Yes ☐ No
2. Other pregnancy complications? ☐ Yes ☐ No

If you answered YES to question 1 or 2, please explain:

_____
_____
_____

**Part 2: Status of Current Pregnancy**

Due Date: \_\_\_\_\_

During this pregnancy, have you experienced:

	Yes	No
Marked fatigue?		
Bloody discharge from the vagina ("spotting")?		
Unexplained faintness/dizziness?		
Unexplained abdominal pain?		
Sudden swelling of the ankles, hands or face?		
Persistent headaches or problems with headaches?		
Swelling, pain, or redness in the calf/leg?		
Absence of fetal movement after the 4 <sup>th</sup> month?		
Failure to gain weight after the 4 <sup>th</sup> month?		

If you answered YES to any of the above questions, please explain: \_\_\_\_\_

**Part 3: Activity Habits During the Past Month**

1. List only regular fitness/recreational activities:

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Intensity	Frequency			Time		
	(times/week)			(minutes/day)		
	1-2	2-4	4+	<20	20-40	40+
Heavy						
Medium						
Light						

2. Does your regular occupation (job/home) activities involve:

	Yes	No
Heavy lifting?		
Frequent walking/stairclimbing?		
Occasional walking (>once/hour)?		
Prolonged standing?		
Mainly sitting?		
Basic daily activities?		

3. Do you currently smoke tobacco?\* ☐ Yes ☐ No4. Do you consume alcohol?\* ☐ Yes ☐ No

\* Pregnant women are strongly advised not to smoke or consume alcohol during pregnancy and lactation.

**Part 4: Physical Activity Intentions**

What physical activities do you intend/hope to do?

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Is this a change from what you currently do? ☐ Yes ☐ No**C Contraindications to Exercise: To be completed by the physician**

Absolute Contraindications			Relative Contraindications/Precautions		
<i>Does the patient have:</i>	Yes	No	<i>Does the patient have:</i>	Yes	No
Ruptured membranes, premature labor?			History of spontaneous abortion or premature labor in previous pregnancies?		
Persistent second or third-trimester bleeding/placenta previa?			Mild/moderate cardiovascular or respiratory disease (e.g. chronic hypertension, asthma)?		
Pregnancy-induced hypertension pre-eclampsia or toxemia?			Anemia or iron deficiency? (Hb < 10 g/dl)?		
Incompetent cervix?			Very low body fat, eating disorder (anorexia, bulimia)?		
Evidence of intrauterine growth retardation?			Twin pregnancy after 28 <sup>th</sup> week?		
Multiple pregnancy (e.g. triplets)?			Other significant medical condition?		
Uncontrolled Type I diabetes, hypertension or thyroid disease, other serious cardiovascular, respiratory or systemic disorder?			Please specify:  <b>NOTE:</b> Risk may exceed benefits of regular physical activity. The decision to be physically active or not should be made with qualified medical advice.		
<b>PHYSICAL ACTIVITY RECOMMENDATION:</b>			<input type="checkbox"/> Recommended/Approved <input type="checkbox"/> Contraindicated		

## **D Health Evaluation Statement & Signatures**

I have discussed my plans to participate in physical activity during my current pregnancy with my physician, and I have obtained his/her approval to begin participation.

Patient/Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Comments: \_\_\_\_\_

\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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\* Reproduced with minor adaptations from the Physical Activity Readiness Medical Examination originally developed by L.A. Wolfe, Ph.D. of Queen's University, Kingston, Ontario and revised by an Expert Advisory Committee assembled by the Canadian Society for Exercise Physiology and the Fitness Program-Health Canada.