BHIP.5
BRUIN HEALTH IMPROVEMENT PROGRAM

HOW TO SUBMIT YOUR APPLICATION (choose one)

Bring it to the FITWELL Services Desk in the John Wooden Center (1st floor) or fax it to 310.825.6321

If you do not receive a confirmation email within 2 business days after submitting your application, contact us at bhip@recreation.ucla.edu

BHIP.5 PRE-PARTICIPATION SCREENING

Check all medical problems you have experienced within one year (unless indicated otherwise). Follow the instructions in each section.

IMPORTANT: If you check *any* of the statements in this section, please have your doctor complete the ***BHIP.5 Physician's Release From*** (see reverse side) prior to submitting your application.

Cardiovascular History

You have had:

- ☐ A heart attack
- ☐ Heart surgery
- ☐ Cardiac catheterization
- ☐ Coronary angioplasty (PTCA)
- ☐ Pacemaker/implantable cardiac defibrillator/rhythm disturbance
- ☐ Heart valve disease
- ☐ Heart failure
- ☐ Heart transplantation
- ☐ Congenital heart disease
- ☐ Heart palpitations
- ☐ You take heart medications

Signs & Symptoms

- ☐ Heart murmur
- ☐ You experience chest discomfort with exertion
- ☐ You experience unreasonable breathlessness or fatigue with usual activities
- ☐ You experience dizziness, fainting, blackouts
- ☐ You have burning or cramping sensation in your lower legs when walking short distances
- ☐ You have circulatory conditions like ankle swelling
- ☐ You have ankle swelling not related to musculoskeletal injury

Other Health Concerns

- ☐ You had a stroke or have cerebrovascular disease
- ☐ You have diabetes or other metabolic disease
- ☐ Your fasting blood glucose level is equal to or greater than 100 mg
- ☐ You have asthma or other lung condition/disease
- ☐ You have a medical diagnosis or disease

Please indicate: _____

- ☐ You have musculoskeletal problems that limit your physical activity
- ☐ You are pregnant
- ☐ You have concerns about the safety of exercise

IMPORTANT: If you check *2 or more* of the statements in this section, please have your doctor complete the BHIP Physician's Release form here prior to submitting your application.

Cardiovascular Risk Factors

- ☐ You are a man 45 years of age or older
- ☐ You are a woman 55 years of age or older, have had a hysterectomy, or are post menopausal
- ☐ You smoke or quit smoking within the previous 6 months
- ☐ Your blood pressure is greater than or equal to 140/90 mmHg or you do not know your blood pressure
- ☐ You take blood pressure medication
- ☐ Your blood cholesterol level is greater than 200 mg/dl or you do not know your cholesterol level
- ☐ You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)
- ☐ You are physically inactive (i.e, you get less than 30 minutes of physical activity on at least 3 days per week)
- ☐ You are more than 20 pounds overweight

☐ I do not have any cardiovascular history, signs or symptoms, cardiovascular risk factors or other health concerns:

Signature _____ Date _____

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BHIP.5 PHYSICIAN'S RELEASE

Dear Doctor:

Your patient _____ wishes to participate in the Bruin Health Improvement Program.5 (BHIP.5), a weight loss program. BHIP.5 is a three-month long weight loss program with physical activity sessions held 3 days/week and a nutrition session held 1 day/week. Physical activity sessions will increase gradually in intensity and incorporate walking, calisthenics, moderate strength training, mobility & flexibility work. All sessions and assessments will be lead by qualified exercise professionals. If you know of any medical or other reasons why participation in the program by the client would be unwise, please indicate so on this form.

Report of Physician

- ○ I know of no reason why the applicant may not participate.
- ○ I believe the patient can participate, but should use caution in the following areas or activities:

  _____

- ○ I believe the patient can participate. The patient, however, is taking medications that will affect heart rate response to exercise. The effects are indicated below:

  Type of Medication _____

  Effect _____

  Restrictions for Exercise _____
- ○ I believe the patient can participate, but *should not* engage in the following activities:

  _____

- ○ I recommend that the client ***not*** participate.

Physician Signature _____ Date _____

Print Name _____ Phone _____

Thank You!

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Fax: 310.825.6321

UCLA Recreation