



PATIENT'S INFORMATION
(Please stick label)

EXERCISE STRESS TEST FORM

☐ CARDIOPULMONARY EXERCISE TESTING (CPET/ Vo2max)

☐ EXERCISE STRESS TESTING

DIAGNOSIS :

PATIENT

Height (cm): Weight (kg): Gender: ☐ Male ☐ Female
Smoker: ☐ Yes ☐ No Active activity: ☐ Yes ☐ No
NYHA : ☐ I ☐ I-II ☐ II ☐ II -III ☐ III ☐ III- IV ☐ IV
Ventricular Function: ☐ Good ☐ Satisfactory ☐ Poor

COMORBIDITY

Asthma : ☐ Yes ☐ No Muscular skeletal abnormalities: ☐ Yes ☐ No
History of stroke : ☐ Yes ☐ No History of seizure: ☐ Yes ☐ No
Hypertension: ☐ Yes ☐ No Obesity: ☐ Yes ☐ No

INDICATION

- | | |
|---|---|
| <input type="checkbox"/> Exercise tolerance | <input type="checkbox"/> Fitness assessment |
| <input type="checkbox"/> Diagnosis of unexplained dyspnea | <input type="checkbox"/> Effectives of therapy |
| <input type="checkbox"/> Exercise induced arrhythmia | <input type="checkbox"/> Grading of heart failure |
| <input type="checkbox"/> Exercise rehabilitation | |
| <input type="checkbox"/> Others (Please state): | |

COMPLICATION

- | | |
|---|--|
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Dyspnea |
| <input type="checkbox"/> Arrhythmia rhythm | <input type="checkbox"/> Pulmonary artery hypertension (PAH) |
| <input type="checkbox"/> Cyanosis oxygen saturation | |
| <input type="checkbox"/> Others (Please state): | |

Physician Order:

Doctor's Name : _____

Signature: _____

Date: _____

Time: _____