Physical Examination

Patient Name: _____ _____ Sex:_____ Age:____ Date of Birth____/____/_____
Last Name First Name
Student ID# _____ Grade_____ Sport(s)_____

Address: _____ Phone:_____

Personal Physician:_____ Address:_____ Phone:_____

Yes	No		
____	____	1.	Have your ever been hospitalized?
____	____	2.	Have you ever had surgery?
____	____	3.	Do you have any allergies?
____	____	4.	Have you ever passed out during or after exercise?
____	____	5.	Have you ever had chest pain during or after any exercise?
____	____	6.	Do you tire more quickly than your friends during exercise?
____	____	7.	Have you ever had high blood pressure?
____	____	8.	Have you ever been told you have a heart murmur?
____	____	9.	Have you ever had racing or your heart or skipped heartbeats?
____	____	10.	Has anyone in your family died of heart problems or a sudden death before age 50?
____	____	11.	Do you have any skin problems (itching, rashes, acne)?
____	____	12.	Have you ever had a head injury?
____	____	13.	Have you ever been knocked out or unconscious?
____	____	14.	Have you ever had a seizure?
____	____	15.	Have you ever been dizzy or passed out in the heat?
____	____	16.	Have you ever had a pinched nerve?
____	____	17.	Do you have trouble breathing or do you cough during or after activity?
____	____	18.	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?
____	____	19.	Have you had any problems with your eyes or vision?
____	____	20.	Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones or joint? ___Head ___Neck ___Back ___Chest ___Shoulder___Upper Arm ___Elbow ___Forearm ___Wrist ___Hand ___Finger ___Hip ___Tight ____Knee ____Shin/Calf ____Ankle ____Feet

Explain "YES" Answers:

_____

Hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

MEDICAL EXAMINATION USE ONLY

Height:_____ Weight:_____ Blood Pressure:_____

Comments:_____
_____

IS THIS CHILD PHYSICALLY FIT TO PARTICIPATE? Yes_____ No_____

Examined by Dr._____ Date:_____

Doctor's Stamp (MANDATORY):_____

	NORMAL	ABNORMAL FINDINGS	DR.'S INITIAL
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heat			
Pulse			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULARSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			