

Sports Physical Form

Name: _____ Gender: M F Date of Birth: ___/___/___
Father's Name: _____ Daytime phone, pager, cell phone: _____
Mother's Name: _____ Daytime, phone, pager, cell phone: _____
Street address: _____
City: _____ State: _____ Zip Code: _____ Home phone: _____
Alternate Emergency Contact Person: _____ Daytime phone: _____
Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.: _____

Medical History:

Athletes and parents: This health record is a critical element in the determination of an athlete's risk of injury in sports. Please take the time to read and answer all questions before seeing a physician for the athlete's physical examination.

- | | | | |
|--|-----|----|------------|
| 1. Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50? | YES | NO | Don't Know |
| 2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? | YES | NO | Don't Know |
| 3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? | YES | NO | Don't Know |
| 4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? | YES | NO | Don't Know |
| 5. Does the athlete have a history of concussion (getting knocked out)? | YES | NO | Don't Know |
| 6. Has the athlete ever suffered a heat-related illness (heat stroke)? | YES | NO | Don't Know |
| 7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? | YES | NO | Don't Know |
| 8. Does the athlete take any medication(s)? | YES | NO | Don't Know |
| 9. Is the athlete allergic to any medications or bee stings? | YES | NO | Don't Know |
| 10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries) | YES | NO | Don't Know |
| 11. Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? | YES | NO | Don't Know |
| 12. Has the athlete had surgery or been hospitalized in the past year? | YES | NO | Don't Know |
| 13. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? | YES | NO | Don't Know |
| 14. Are you, the athlete, worried about any problem or condition at this time? | YES | NO | Don't Know |

Please give details on any "YES" answer from the above health history.

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision: R _____ / _____ uncorrected R _____ / _____ corrected L _____ / _____ uncorrected L _____ / _____ corrected

| | Normal | Abnormal Findings | Initials |
|--|--------|-------------------|----------|
| 1. Eyes | | | |
| 2. Ears, Nose, Throat | | | |
| 3. Mouth & Teeth | | | |
| 4. Neck | | | |
| 5. Cardiovascular | | | |
| 6. Chest & Lungs | | | |
| 7. Abdomen | | | |
| 8. Skin | | | |
| 9. Genitalia-Hernia (male) | | | |
| 10. Muskuloskeletal: ROM, strength, etc. | | | |
| a. neck | | | |
| b. spine | | | |
| c. shoulders | | | |
| d. arms/ hands | | | |
| e. hips | | | |
| f. thighs | | | |
| g. knees | | | |
| h. ankles | | | |
| i. feet | | | |
| 11. Neuromuscular | | | |

Please Print/ Stamp

Physician's Name _____
 Street Address _____
 City, State, Zip Code _____
 Telephone _____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature _____ Date _____

PARTICIPATION RESTRICTIONS: _____

