

## PHYSICAL EXAMINATION FORM

### **PLEASE TAKE NOTICE**

Physcials performed by nurse practitioners or physician assistants must list name, address and phone number of the supervising physician. Physicals completed incorrectly will be considered <u>incomplete</u> and returned to the athlete.

SPORT:					
Athlete's Name:		Birthdate:			
Height:	Weight:				
Pulse:	BP:				
Vision: R: 20/ L: 20/	/ Pupils: Equal Unequal				
Glasses: Y/N	18	Contacts: Y/N			
MEDICAL	<u>Normal</u>	<b>Abnormal Findings</b>	<u>Initials</u>		
Eyes/Ears/Nose/Throat					
Lymph Nodes					
Heart					
Lungs		34 /51			
Pulses	15	1/8			
Abdomen	150	Mig			
Hernia		JON OF .			
Skin					
MUSCULOSKELETAL					
Neck					
Back					
Shoulder/Arm					
Elbow/Forearm					
Wrist/Hand					
Hip/Thigh					
Knee					
Leg/Ankle					
Foot					
<u>CLEARANCE</u> A. Cleared	•				
A. Cleared B. Cleared afer completing evaluation	on/robabilitation	for			
C. Not Cleared For:	ony i enabilitatiON	101.			
C. 1101 Cicarca 1 01.					
Examiner's Name (please print)	Exa	aminer's Signature	 Date		
Examiner's address			Examiner's Phon		

if exam performed by NP or PA, name, address, and phone number of supervising physician (if different)



### (CONTINUED)

# Medication: (please circle one of the following)

Phone Number:

<u>wiedication: (please circle one of the following)</u>	<u>List the medication, pilis, supplements</u>		
I am NOT currently taking any medications/pills	N/A		
I AM currently taking medication/pills			
I am NOT currently taking any supplements	N/A		
I AM currently taking supplements			
Name of Primary Care Physician:			
Address:			
Phone number:	D & SRE		
23	P. C.		
Name of Health Insurance Provider:			
Name of Policy Holder:			
Policy Number:			
Effective Date:	24 /4/		
Expiration Date:	- / / R		



# **CURRENT MEDICAL HISTORY SUMMARY**

Condition?	Yes	No	Condition??	Yes2	No2
Bone, joint, or other deformity			Eye trouble		
Stomach, liver, or intestinal trouble			Severe tooth or gum trouble		
Ear, nose, or throat trouble			Loss of finger or toe		
Gallbladder trouble or gall stones			Jaundice or Hepatitis		
Chronic or frequent colds			Hearing loss		
Recurrent back pain			Broken Bones		
Rupture or Hernia			Hay Fever		
Sinusitis			Neuritis		
Tumor, growth, cyst, or cancer			Frequent or painful urination		
Head injury			Skin Disease		
Paralysis			Epilepsy		
Piles or rectal disease	/	8	Kidney stone or blood in urine		
Thyroid trouble			Tuberculosis		
Car, train sea or air sickness			Frequent trouble sleeping		
Asthma			Frequent Indigestion		
Depression or excessive worrying	1		Shortness of Breath		
Pain or pressure in chest			Loss of memory or amnesia		
High or low blood pressure		13	Venereal disease		
Scarlet fever			Palpation or pounding heart		
Recent weight loss or gain			Rheumatic Fever		
Heart trouble			Leg cramps		
Swollen/painful joints			Chronic Cough		
Frequent/Severe headache			Adverse reaction to serum drug or medicine		
Dizziness or fainting spells			Arthritis, rheumatism, or bursitis		
Diabetes			Night sweats		

Explain "Yes" answers:

Blood type:	Date of most recent Teti	nus Toxoid Vaccine:
Past surgical procedures (attac	h additional page if necessary):	
1		Date:
2		
3		Date:
Allergies:	Reaction	