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.: ______________________

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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.

	Question			
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	YES	NO	Don't Know
	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.

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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.

Physician Signature ______________________________ Date __________

PARTICIPATION RESTRICTIONS: ______________________________

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