

## Sports Physical Form

Name: \_\_\_\_\_ Gender: M F Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Father's Name: \_\_\_\_\_ Daytime phone, cell phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Daytime phone, 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.

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|--|-----|----|------------|
| 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.

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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. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

This physical is valid for one year after the signed date.

**PARTICIPATION RESTRICTIONS:** \_\_\_\_\_  
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