Sports Physical Form

Athlete's full name:: _____ **Date of birth::** _____ dd / mm / yyyy

Age:: _____

Sex:

◯ Male ◯ Female

Address:

Contact Address:

Email:: _____ **Sport::** _____

Date of form submission:: _____ dd / mm / yyyy **School::** _____

Grade:: _____ **Father's name and contact details::** _____

Mother's name and contact details:: _____ **Sports team::** _____

Emergency contact:: _____

1. Has a doctor ever restricted/denied your participation in sports?

◯ Yes ◯ No

2. Have you ever been hospitalized or spent a night in a hospital?

◯ Yes ◯ No

3. Have ever had surgery?

◯ Yes ◯ No

4. Do you have any ongoing medical conditions (like Diabetes or Asthma)?

◯ Yes ◯ No

5. Are you presently taking any medications or pills (prescription or over-the-counter?

◯ Yes ◯ No

6. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?

◯ Yes ◯ No

7. Have you ever passed out during or after exercise?

◯ Yes ◯ No

8. Have you ever been dizzy during or after exercise?

◯ Yes ◯ No

9. Have you ever had chest pain or discomfort in your chest during or after exercise?

◯ Yes ◯ No

10. Do you tire more quickly than your friends during exercise?

◯ Yes ◯ No

11. Have you ever had high blood pressure?

◯ Yes ◯ No

12. Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?

◯ Yes ◯ No

13. Have you ever had a racing of your heart or skipped heartbeats?

◯ Yes ◯ No

14. Has anyone in your family died of heart problems or sudden death before age 50?

◯ Yes ◯ No

15. Does anyone in your family have a heart condition?

◯ Yes ◯ No

16. Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?

◯ Yes ◯ No

17. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?

◯ Yes ◯ No

18. Have you ever had a head injury or concussion?

◯ Yes ◯ No

19. Have you ever been knocked out or unconscious?

◯ Yes ◯ No

20. Have you ever had a seizure?

◯ Yes ◯ No

21. Have you ever had a stinger, burner, pinched nerve, or loss of feeling, or weakness in your arms or legs?

◯ Yes ◯ No

22. Have you ever had heat or muscle cramps?

◯ Yes ◯ No

23. Have you ever been dizzy or passed out in the heat?

◯ Yes ◯ No

24. Do you have trouble breathing or do you cough during or after activity?

◯ Yes ◯ No

25. Do you take any medications for asthma (for instance, inhalers)?

◯ Yes ◯ No

26. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?

◯ Yes ◯ No

27. Have you had any problems with your eyes or vision?

◯ Yes ◯ No

28. Do you wear glasses or contacts or protective eyewear?

◯ Yes ◯ No

29. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?

◯ Yes ◯ No

30. Have you had a medical problem or injury since your last evaluation?

◯ Yes ◯ No

31. Have you ever been told you have sickle cell trait?

◯ Yes ◯ No

32. Has anyone in your family had sickle cell disease or sickle cell trait?

◯ Yes ◯ No

33. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?

◯ Yes ◯ No

34. When was your first menstrual p... _____ 35. When was your last menstrual pe... _____

36. What was the longest time between your periods last year?: _____

Signature of athlete:

Date:: _____ dd / mm / yyyy

Signature of parent/guardian (if student):

PHYSICAL EXAMINATION

Height:: _____ Weight:: _____

Pulse:: _____ Blood Pressure:: _____

Vision: R 20/: _____ L20/: _____

Vision Corrected:

◯ Yes ◯ No

Cardiovascular:

◯ Normal ◯ Abnormal

Pulses:

◯ Normal ◯ Abnormal

Heart:

◯ Normal ◯ Abnormal

Lungs:

◯ Normal ◯ Abnormal

Skin:

◯ Normal ◯ Abnormal

E.N.T.:

◯ Normal ◯ Abnormal

Abdominal:

◯ Normal ◯ Abnormal

Genitalia (males):

◯ Normal ◯ Abnormal

Musculoskeletal:

◯ Normal ◯ Abnormal

Neck:

◯ Normal ◯ Abnormal

Shoulder:

◯ Normal ◯ Abnormal

Elbow:

◯ Normal ◯ Abnormal

Wrist:

◯ Normal ◯ Abnormal

Hand:

◯ Normal ◯ Abnormal

Back:

◯ Normal ◯ Abnormal

Knee:

◯ Normal ◯ Abnormal

Ankle:

◯ Normal ◯ Abnormal

Foot:

◯ Normal ◯ Abnormal

Other:

◯ Normal ◯ Abnormal

Abnormal Findings:

Clearance:

◯ A. Cleared ◯ B. Cleared after completing evaluation/rehabilitation for: ◯ C. Not cleared

Due to:

Recommendation:

Name of physician:: _____ **Date::** _____ dd / mm / yyyy

Address:

Phone:: _____

Signature of physician: , M.D. or D.O.