

Physical Examination *(To be completed by physician, ARNP, PA)*

TO THE EXAMINER: Please complete the PHYSICAL EXAMINATION below. Please comment on all pertinent findings and be sure all information is complete. *Please include summary of the student's pertinent conditions/treatments and medications.

NAME _____ SEX: ____ M ____ F DATE OF BIRTH ____/____/____

BLOOD PRESSURE _____ PULSE _____ WEIGHT _____ HEIGHT _____

VISUAL ACTIVITY: OD 20/ _____ OS 20/ _____ CORRECTIVE LENSES: (with / without) *please circle

History

- | | YES | NO |
|--|--------------------------|--------------------------|
| • Prior exertional chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| • Prior exertional syncope/near syncope | <input type="checkbox"/> | <input type="checkbox"/> |
| • Excessive, unexplained shortness of breath or fatigue with exercise | <input type="checkbox"/> | <input type="checkbox"/> |
| • Prior history of heart murmur or increased blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| • Family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50 | <input type="checkbox"/> | <input type="checkbox"/> |

Exam "WNL" - or note abnormalities

MENTAL/EMOTIONAL STATUS _____

SKIN _____

HEENT _____

NECK, THYROID _____

LUNGS _____

HEART (MURMUR, DYSRHYTHMIA?) _____

ABDOMEN _____

EXTREMITIES _____

NEUROLOGICAL _____

GENITALS/HERNIA _____

Laboratory *(if needed)*

HGB/HCT: _____ URINE: (DIP) _____

PERTINENT PAST MEDICAL/PSYCHOLOGICAL HISTORY
(include dates of surgeries)

CURRENT MEDICATIONS:

ALLERGIES TO MEDICINE/FOOD/OTHER?

ANY RESTRICTIONS ON SPORTS PARTICIPATION?

PAST INJURIES	YES	NO	WHEN
Concussion(s) No.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skull fracture(s) No.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoulder injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elbow injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arm/wrist/hand injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rib cage injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hip injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thigh injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lower leg injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shin splints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

HEALTH CARE PROVIDER (MD, ARNP, or PA). PLEASE PRINT NAME & ADDRESS, THEN SIGN.

MD/ARNP/PA _____ DATE _____

ADDRESS _____ TEL. _____

SIGNATURE _____ FAX # _____