

PHYSICAL EVALUATION—MEDICAL HISTORY

Name:(Print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Personal Physician _____ Phone _____

In Case of Emergency Contact:

Name _____ Relationship _____ Phone (H) _____ Phone (W) _____

1. Have you had a medical illness or injury since your last check up? Yes __ No __
2. Have you been hospitalized overnight in the past year? Yes __ No __
Have you ever had surgery? Yes __ No __
3. Have you ever passed out during or after exercise? Yes __ No __
Have you ever had chest pain during or after exercise? Yes __ No __
Do you get tired more quickly than others do during exercise? Yes __ No __
Have you ever had racing of your heart or skipped heartbeats? Yes __ No __
Have you had high blood pressure or high cholesterol? Yes __ No __
Have you ever been told you have a heart murmur? Yes __ No __
Has any family member or relative died of heart problems or of sudden unexpected death before the age of 50? Yes __ No __
Has any family member been diagnosed with enlarged heart, Hypertrophic cardiomyopathy, long QT syndrome, Marfan's Syndrome, or abnormal heart rhythm)? Yes __ No __
Have you ever had a severe viral infection (for example, myocarditis Or mononucleosis) within the last month? Yes __ No __
4. Have you ever had a head injury or concussion? Yes __ No __
Have you ever been knocked out, become unconscious, or Lost your memory? Yes __ No __
Have you ever had a seizure? Yes __ No __
Do you have frequent or severe headaches? Yes __ No __
Have you ever had numbness or tingling in your arms, hands Legs, or feet? Yes __ No __
Have you ever had a stinger, burner, or pinched nerve? Yes __ No __
5. Are you missing any paired organs? Yes __ No __
6. Are you under a doctor's care? Yes __ No __
7. Are you currently taking any prescription or non-prescription (over the counter) medication or pills or using and inhaler? Yes __ No __
8. Do you have any allergies (for example, to pollen, medicine, Food, or stinging insects)? Yes __ No __
9. Have you ever been dizzy during or after exercise? Yes __ No __
10. Do you have any current skin problems (for example, itching, Rashes, acne, warts, fungus, or blisters)? Yes __ No __
11. Have you ever been sick from exercising or working in the heat? Yes __ No __
12. Have you had any problems with your eyes or vision? Yes __ No __
13. Have you gotten unexpectedly short of breath with exercising Or working? Yes __ No __
Do you have asthma? Yes __ No __
Do you have seasonal allergies that require medical treatment? Yes __ No __
14. Do you use any special protective or corrective equipment or Devices that aren't usually used for your position (for example, Knee brace, special neck roll, foot orthotics, retainer on your teeth Hearing aid)? Yes __ No __
15. Have you ever had a sprain, strain, or swelling after injury? Yes __ No __
Have you broken or fractured any bones dislocated any joints? Yes __ No __
Have you had any other problems with pain or swelling in Muscles, tendons, bones, or joints? Yes __ No __

If yes, check appropriate box and explain.

- | | | |
|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper Arm | <input type="checkbox"/> | <input type="checkbox"/> Foot |

***Explain "Yes" Answers Below (attach another sheet if necessary)

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature: _____ Date: _____

Physical Examination

Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Auscultation of the heart in the standing position			
Heart-Lower Extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			

Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Clearance

Cleared

Cleared after competing evaluation/rehabilitation for:

Not cleared for: _____ Reason: _____

Recommendations:

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination _____

Address: _____

Phone Number: _____

Signature: _____