

Physician's Physical Examination

Athlete's Name _____ Date of Exam _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20/____ L 20/____ Corrected Y N

<u>Medical</u>	<u>Normal</u>	<u>Abnormal (explain)</u>
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Chest and Cardiovascular		
Lungs		
Abdomen		
Skin		

Skeletal (record laxity, weakness, instability, decreased ROM)

Feet		
Ankle		
Knee		
Hip		
Spine		
Neck		
Shoulder		
Elbow		
Wrist and Hand		
Strength		
Flexibility		
Alignments		

Clearance

- _____ Cleared = no limitations for participation
- _____ Limited to specific sports of _____
- _____ Deferred – clearance withheld until _____
- _____ Denied clearance – may not participate for reason of _____

Physician's Signature Date

Phone _____ Are you licensed to practice in NC? _____

Explain any YES answers in the space provided. Circle questions of uncertainty.

	Yes	No
1. Are you currently taking any prescription or nonprescription medications or pills?		
2. Do you have any allergies? (for example to pollen, medicine, food or stinging insects)		
3. Have you ever passed out during or after exercise?		
4. Have you ever had chest pain during or after exercise?		
5. Have you had high blood pressure or high cholesterol?		
6. Have you ever been told you have a heart murmur?		
7. Has any family member or relative died of heart related problems or sudden death before the age of 50?		
8. Have you had a severe viral infection (for example, myocarditis or mononucleosis) in the last month?		
9. Has a physician ever denied or restricted your participation in sports for any heart problem?		
10. Have you ever had a head injury or concussion, ever become unconscious, or lost your memory?		
11. Have you ever had a seizure or frequent severe headaches?		
12. Have you ever had numbness or tingling in your arms, hands, legs or feet? Have you ever had a stinger, burner, or		
13. Have you ever become ill from exercising in the heat?		
14. Do you cough, wheeze, or have trouble breathing during or after an activity?		
15. Do you have asthma or seasonal allergies that require medication?		
16. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example - knee brace, special neck roll, foot orthotics, retainer, hearing aid)?		
17. Do you wear glasses, contacts or protective eyewear?		
18. Have you had a problem with pain, swelling, fractures or dislocations with any of the muscles, tendons, bones or joints in the following areas? _____ Head, _____ Upper Arm/Elbow, _____ Hip/Thigh, _____ Neck/Back, _____ Forearm, _____ Knee, _____ Chest, _____ Waist, _____ Shin/Calf, _____ Shoulder, _____ Hand/Fingers, _____ Ankle/Foot		

Please explain any YES answers here
