

**PHYSICAL EXAMINATION**

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Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ yrs \_\_\_\_ mos

Male/Female Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_  
.....

Physical Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Immunizations: Reviewed \_\_\_\_\_ and Attached \_\_\_\_\_

Physically Fit and Able to Play Sports: YES / NO / Restrictions are \_\_\_\_\_  
\_\_\_\_\_

**HEALTH HISTORY** [Please check all that apply]

\_\_\_\_ Drug allergy [specify] \_\_\_\_\_ Reaction \_\_\_\_\_ Tx \_\_\_\_\_

\_\_\_\_ Food allergy \_\_\_\_\_ Reaction \_\_\_\_\_ Tx \_\_\_\_\_

\_\_\_\_ Environmental \_\_\_\_\_ Reaction \_\_\_\_\_ Tx \_\_\_\_\_

\_\_\_\_ Asthma [type & med] \_\_\_\_\_ Well controlled - YES/NO

\_\_\_\_ ADD/ADHD [med] \_\_\_\_\_ Well controlled - YES/NO

\_\_\_\_ Diabetes [type, age of onset, med] \_\_\_\_\_ Well controlled - YES/NO

\_\_\_\_ Seizure disorder [type & med] \_\_\_\_\_ Well controlled - YES/NO

\_\_\_\_ Bleeding issue [type & med] \_\_\_\_\_ Well controlled - YES/NO

\_\_\_\_ Heart condition [type & med] \_\_\_\_\_ Limitations \_\_\_\_\_

\_\_\_\_ Surgery [type] \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Limitations \_\_\_\_\_

\_\_\_\_ Injuries [fx, dislocations, etc; specify] \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Concussion Date \_\_\_\_/\_\_\_\_/\_\_\_\_ How occurred \_\_\_\_\_  
LOC: YES/NO – Duration \_\_\_\_ sec \_\_\_\_ min \_\_\_\_ hr/s Seizure activity: YES/NO – Duration \_\_\_\_ sec \_\_\_\_ min  
Side effects \_\_\_\_\_

\_\_\_\_ Migraines [type & med] \_\_\_\_\_ Well controlled – YES/NO

\_\_\_\_ Heat exhaustion/Heat stroke Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Severity \_\_\_\_\_

\_\_\_\_ Glasses/contacts [specify which & need for] \_\_\_\_\_

\_\_\_\_ Braces [oral, arm, leg, back, neck & reason for] \_\_\_\_\_

\_\_\_\_ **OTHER** \_\_\_\_\_ (additional info continued to back of page: yes / no)  
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**Medical Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**AND OFFICE STAMP**