ATHLETIC PHYSICAL EXAMINATION FORM

***TO BE COMPLETED BY PHYSICIAN* (MD, DO, PA, NP)**

(Unable to accept Chiropractors signatures)

Name _____________________ Social Security No. _______________________Sport ______________
Height _________ Weight ________ Blood Pressure _________ Pulse ________ Temp _____________

Vision: R 20/_____L 20/_____ Corrective Lenses Yes___ No___ Corrected Vision R20/____L20/___
Immunization Dates: Measles or MR ________ TD or Tetanus ________

Physical Exam (Please elaborate on any abnormality in the history)

	Normal	Abnormal	Describe Abnormality in Detail
Head, Face, and Scalp			
Mouth, Nose & Throat			
Tonsils In ( ) Out ( )			
Ears			
Eyes			
Neck (thyroid)			
Lymph Nodes			
Lungs and Chest			
Breasts			
Heart			
Vascular System			
Abdomen (include hernias)			
Genitalia			
Musculoskeletal (strength and range of motion			
Neck			
Shoulders			
Elbows			
Hands/Wrists			
Spine			
Knees			
Ankles			
Feet			
Skin			
Neurologic			

Assessment:

Recommendations/preventative measures:

CLEARANCE (Circle appropriate category)

1. No limitations to contact/collision
2. Limited contact/impact
3. No contact
4. Clearance deferred until seen by specialist

Physician's Name ________________________________

Physician's Signature _____________________________

Phone: ________________________ Date: __________

Attach Stamp or Business Card to this form.

PHYSICAL SCREENING
This screening physical exam is for the purpose of participation in intercollegiate athletics at Marion Military institute. This physical exam is a confidential document. Please answer medical history questions accurately

Sport ____________________
Male or Female _____________

NAME _________________________________ BIRTHDATE ______________ SS# ______________________
ADDRESS____HOME PHONE NO. ________________
____EMERGENCY PHONE NO. ____________________

Explain "YES" answers below.

		Yes	No				
1.	Have you had a medical illness or injury since your last sports physical?			25.	Do you cough, wheeze, or have trouble breathing during or after activity?		
2.	Do you have an ongoing illness?			26.	Do you have asthma?		
3.	Have you ever been hospitalized overnight?			27.	Do you have seasonal allergies that require treatment?		
4.	Have you ever had surgery?			28.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position?		
5.	Are you currently take prescription or over the counter medications or using an inhaler?			29.	Have you had any problems with your eyes or vision?		
6.	Have you ever taken supplements or vitamins to help you gain or lose weight to improve your performance?			30.	Have you ever had a sprain, stain, or swelling after injury?		
7.	Do you have allergies? If yes, to what?			31.	Have you broken or fractured any bones or dislocated any joints?		
8.	Have you ever had a rash or hives develop during or after exercise?			32.	Do you want to weigh more or less than you do now?		
9.	Have you ever passed our during exercise?			33.	Do you lose weight regularly to meet weight requirements for your sport?		
10	Have you ever had chest pain during or after exercise?			34.	Record the dates of your most recent immunizations for: Tetanus: Measles Hepatitis B Chickenpox		
11	Have you ever had racing of your heart or skipped beats?				**FEMALE ATHLETES ONLY**		
12	Have you had high blood pressure or high cholesterol?			35.	When was your first menstrual period?		
13	Have you ever been told you have a heart murmur?			36.	When was your most recent menstrual period?		
14	Has any family member died of heart problems or of sudden death before the age of 50?			37.	How much time do you usually have from the start of one period to the start of another?		
15 .	Have you had a severed viral infection (for example mono or myocarditis) within the last month?			38.	How many periods have you had in the last year?		
16	Has a physical ever denied or restricted your participation in sports for any heart problems?			39.	What was the longest time between periods in the last year?		
17	Have you ever had a head injury or concussion? If yes, how many and the year.			40.	Is there any possibility you may be currently pregnant?		
18	Have you ever had a seizure?						
19	Do you have frequent or severe headaches?						
20	Have you ever had numbness or tingling in your arms, hands, legs or feet?						
21	Have you ever had a burner or stinger, or pinched nerve?						
22	Have you ever become ill from exercising in the heat?						

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