ATHLETIC PHYSICAL EXAMINATION FORM

TO BE COMPLETED BY PHYSICIAN **ie, MD, DO, PA, NP**

(Unable to accept Chiropractors signatures)

Name _____Social Security No._____Sport_____
Height_____ Weight _____Blood Pressure _____Pulse _____Temp _____

Vision; R20/ _____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
   a. strenuous b. non-strenuous
4. Clearance deferred until seen by team physician or specialist

Physician's Name_____

Physician's Signature_____

Phone: _____ Date:_____

Attach Stamp or business Card

Sport _____
Male or Female_____

PHYSICAL SCREENING

This screening physical exam is for the purpose of participation in intercollegiate athletics at **Phoenix College**.
This physical exam is a confidential document. Please answer medical history questions accurately.

NAME_____BIRTHDATE_____SOCIAL SECURITY_____
ADDRESS_____HOME PHONE NUMBER_____
_____EMERGENCY PHONE NUMBER_____
CITY STATE ZIP

	Explain ALL "YES" answers below.	**Yes**	**No**			**Yes**	**No**
1.	Have you had a medical illness or injury since your last sports physical?			26.	Do you cough, wheeze, or have trouble breathing during or after activity?		
2.	Do you have an ongoing illness?			27.	Do you have asthma?		
3.	Have you ever been hospitalized overnight?			28.	Do you have seasonal allergies that require treatment?		
4.	Have you ever had surgery?			29.	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 taking prescription or over the counter medications or using an inhaler?			30.	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 or improve your performance?			31.	Have you ever had a sprain, strain, or swelling after injury?		
7.	Do you have any allergies? Is yes, to what?			32.	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?			33.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		
9.	Have you ever passed out during exercise?			***	If YES #30 – 32, circle appropriate location and explain below. Head, Neck, Back, Chest, Shoulder, Upper Arm, Elbow, Forearm, Wrist, Hand, Finger, Hip, Thigh, Knee, Shin/Calf, Ankle, Foot		
10.	Have you ever been dizzy during or after exercise?						
11.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?						
12.	Have you ever had chest pain during or after exercise?			34.	Do you want to weigh more or less than you do now?	More	Less
13.	Have you ever had racing of your heart of skipped beats?			35.	Do you lose weight regularly to meet weight requirements for your sport?		
14.	Have you had high blood pressure or high cholesterol?			36.	Record the dates or your most recent immunizations for: Tetanus, Measles, Hepatitis B, Chickenpox		
15.	Have you ever been told you have a heart murmur?						
16.	Has any family member died of heart problems or of sudden death before the age of 50?				**Explain ALL "YES" answers here: Include date where applicable**		
17.	Have you had a severe viral infection (for example mononucleosis or myocarditis) within the last month?						
18.	Has a physician ever denied or restricted your participation in sports for any heart problems?						
19.	Do you have any current skin problems?				**FEMALE ATHLETES ONLY**		
20.	Have you ever had a head injury or concussion? If yes, how many and the year.			37.	When was your first menstrual period?		
21.	Have you ever had a seizure?			38.	When was your most recent menstrual period?		
22.	Do you have frequent or severe headaches?			39.	How much time do you usually have from the start of one period to the start of another?		
23.	Have you ever had numbness or tingling in your arms, hands, legs or feet?			40.	How many periods have you had in the last year?		
24.	Have you ever had a burner or stinger, or pinched nerve?			41.	What was the longest time between periods in the last year?		
25.	Have you ever become ill from exercising in the heat?			42.	Is there any possibility you may currently be pregnant?		

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

Signature of athlete_____ Date_____

Signature of parent**_____ Date_____

**Must be signed by parent/guardian if athlete is under the age of 18.