Sports Physical Form

Athlete's full name: _____ Date of birth: _____

Age: ____ Sex: _____ Address: _____

Contact number: _____ Email address: _____

Sport: _____

Date of form submission: _____

If you're a student:

School: _____ Grade: _____

Father's name and contact details: _____

Mother's name and contact details: _____

If you're a professional athlete:

Sports team: _____

Emergency contact: _____

Questions	Yes	No
1. Has a doctor ever restricted/denied your participation in sports?	☐	☐
2. Have you ever been hospitalized or spent a night in a hospital?	☐	☐
3. Have ever had surgery?	☐	☐
4. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	☐	☐
5. Are you presently taking any medications or pills (prescription or over-the-counter?	☐	☐
6. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	☐	☐
7. Have you ever passed out during or after exercise?	☐	☐
8. Have you ever been dizzy during or after exercise?	☐	☐
9. Have you ever had chest pain or discomfort in your chest during or after exercise?	☐	☐
10. Do you tire more quickly than your friends during exercise?	☐	☐
11. Have you ever had high blood pressure?	☐	☐
12. Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?	☐	☐
13. Have you ever had a racing of your heart or skipped heartbeats?	☐	☐
14. Has anyone in your family died of heart problems or sudden death before age 50?	☐	☐
15. Does anyone in your family have a heart condition?	☐	☐
16. Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	☐	☐
17. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	☐	☐
18. Have you ever had a head injury or concussion?	☐	☐

Questions	Yes	No
19. Have you ever been knocked out or unconscious?	☐	☐
20. Have you ever had a seizure?	☐	☐
21. Have you ever had a stinger, burner, pinched nerve, or loss of feeling, or weakness in your arms or legs?	☐	☐
22. Have you ever had heat or muscle cramps?	☐	☐
23. Have you ever been dizzy or passed out in the heat?	☐	☐
24. Do you have trouble breathing or do you cough during or after activity?	☐	☐
25. Do you take any medications for asthma (for instance, inhalers)?	☐	☐
26. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☐
27. Have you had any problems with your eyes or vision?	☐	☐
28. Do you wear glasses or contacts or protective eyewear?	☐	☐
29. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	☐	☐
30. Have you had a medical problem or injury since your last evaluation?	☐	☐
31. Have you ever been told you have sickle cell trait?	☐	☐
32. Has anyone in your family had sickle cell disease or sickle cell trait?	☐	☐
33. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ☐ Head ☐ Back ☐ Shoulder ☐ Forearm ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Neck ☐ Chest ☐ Elbow ☐ Wrist ☐ Finger ☐ Thigh ☐ Shin ☐ Foot	☐	☐
34. When was your first menstrual period? _____		
35. When was your last menstrual period? _____		
36. What was the longest time between your periods last year? _____		

Please note that your physician will ask you about the items you answered Yes to during the examination.

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

Signature of athlete: _____ Date: _____

Signature of parent/guardian (if student): _____

Physical Examination

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

Vision: R 20 /_____, L 20 /_____ **Vision Corrected:** ☐ Yes ☐ No

	Normal	Abnormal Findings
Cardiovascular		
Pulses		
Heart		
Lungs		
Skin		
E.N.T.		
Abdominal		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

Clearance:

☐ A. Cleared
☐ B. Cleared after completing evaluation/rehabilitation for: _____
☐ C. Not cleared

Due to: _____

Recommendation: _____

Name of physician: _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____ , M.D. or D.O.