

**Side A – To be completed by the athlete prior to the physical examination.**

<b>Last Name:</b>		<b>First Name:</b>		<b>Date:</b>	
<b>Date of Birth:</b>		<b>Age:</b>	<b>Graduation:</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>School:</b> <i>Saint Francis University</i>		<b>Sport:</b>		<b>School Phone:</b>	
<b>Address:</b>					
				<b>Home Phone:</b>	
<b>Mother's Name:</b>			<b>Father's Name:</b>		
<b>Mother's Work Phone:</b>			<b>Father's Work Phone:</b>		
<b>Family Physician:</b>			<b>Physician's Phone:</b>		

**Medical History – Please provide complete information in the comment section for all positive items.**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Concussion / Head Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting / Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Absence of Paired Organ (ie: Kidney, Eye, Testicle)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures / Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lumps or Cysts
<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems (excluding corrective lenses)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heat Cramps, Exhaustion, or Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No	Wear glasses or contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Problems or Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent Ear Aches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Nose Bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease / Trait
<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Sore Throats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emotional Problems or Psychiatric Disorder
<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Extreme Measures to Control Weight
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease or High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette Smoking / Chewing Tobacco
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol or Drug Problem
<input type="checkbox"/> Yes <input type="checkbox"/> No	Extra or Skipped Heart Beats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anabolic Steroid Use
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other conditions, symptoms, or concerns
<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic or Sports Injury
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Respiratory Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently being treated by a physician?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough during or after exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been hospitalized?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had surgery?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Nausea, Vomiting, or Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently taking any medications?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking any nutritional supplements?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any allergies?

<b>Family History</b>	<i>None</i>	<i>Father</i>	<i>Mother</i>	<i>Siblings</i>	<i>Father's Parents</i>	<i>Father's Siblings</i>	<i>Mother's Parents</i>	<i>Mother's Siblings</i>
Heart Disease / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Bone or Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden death before age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Female</b>	Age of first menstrual period:	Length of menstrual cycle:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Pregnant
	Menstrual Cycle: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	Days of menstrual flow:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prior Pregnancies

**Comments:**

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I certify that this information is accurate to the best of my knowledge, and I give Saint Francis University permission to complete the physical examination.

**Athlete's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Side B** – To be completed by the medical staff during the physical examination.

<b>Last Name:</b>		<b>First Name:</b>		<b>Date of Exam:</b>		
<b>Height:</b>	<b>Weight:</b>	<b>Blood Pressure:</b>	<b>Pulse:</b>	<b>Respirations:</b>		
<b>Medical Assessment</b>						
PMH: <input type="checkbox"/> None						
PSH: <input type="checkbox"/> None						
Meds: <input type="checkbox"/> None						
Allg: <input type="checkbox"/> None						
HEENT	<input type="checkbox"/> Normocephalic; PERRLA; Pharynx: normal				<b>Comments:</b>	
Neck	<input type="checkbox"/> Thyroid: normal; Ø lymphadenopathy					
Chest	<input type="checkbox"/> Heart: RRR; Ø murmurs, gallops, or rubs					
	<input type="checkbox"/> Lungs: CTA, equal B/L; Ø wheezing					
Abdomen	<input type="checkbox"/> Soft, NT/ND; Ø organomegaly, masses, or hernia					
Genitalia	<input type="checkbox"/> Male: normal; Testicles: equal size; Ø masses					
	<input type="checkbox"/> Female: Deferred					
Back	<input type="checkbox"/> Normal inspection; Ø CVA or spinal tenderness					
Extremities	<input type="checkbox"/> Normal inspection; deferred to orthopedic examination					
Skin	<input type="checkbox"/> Normal color, warm, dry; Ø lesions or masses					
Neuro	<input type="checkbox"/> AA&O; CN 2-12, sensory, motor, and cerebellum intact					
<b>Medical Disposition</b>		<input type="checkbox"/> Clearance withheld pending follow-up		<b>Physician Signature:</b>		
<input type="checkbox"/> Certified, Unrestricted		<input type="checkbox"/> Cleared for limited participation				
		<input type="checkbox"/> Not cleared for participation				
<b>Orthopedic Assessment</b>						
Injuries: <input type="checkbox"/> None						
Surgery: <input type="checkbox"/> None						
Spine	<input type="checkbox"/> Cervical: normal curvature, FROM				<b>Comments:</b>	
	<input type="checkbox"/> Thoracic: normal curvature; FROM					
	<input type="checkbox"/> Lumbar: normal curvature; FROM					
Upper Extremity	<input type="checkbox"/> Normal inspection; motor and sensory intact					
	<input type="checkbox"/> Shoulders: joints stable; FROM					
	<input type="checkbox"/> Elbows: joints stable; FROM					
Lower Extremity	<input type="checkbox"/> Wrists / Hands: joints stable; FROM					
	<input type="checkbox"/> Normal inspection; motor and sensory intact					
	<input type="checkbox"/> Hips / Pelvis: joints stable; FROM					
	<input type="checkbox"/> Knees: joints stable; FROM					
	<input type="checkbox"/> Ankles / Feet: joints stable; FROM					
<b>Orthopedic Disposition</b>		<input type="checkbox"/> Clearance withheld pending follow-up		<b>Physician Signature:</b>		
<input type="checkbox"/> Certified, Unrestricted		<input type="checkbox"/> Cleared for limited participation				
		<input type="checkbox"/> Not cleared for participation				
<b>Comments:</b>						