PHYSICAL EVALUATION – TO BE FILLED OUT BY DOCTOR

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_

HEIGHT \_\_\_\_\_\_\_ WEIGHT \_\_\_\_\_\_\_ PULSE \_\_\_\_\_\_\_ BP \_\_\_/\_\_\_\_

VISION R20/\_\_\_\_\_ CORRECTED: Y N PUPILS: EQUAL \_\_\_\_ UNEQUAL \_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | NORMAL | ABNORMAL  FINDINGS | INITIALS |
| MEDICAL |  |  |  |
| APPEARANCE |  |  |  |
| EYES/EARS/NOSE/THROAT |  |  |  |
| LYMPH NODES |  |  |  |
| HEART |  |  |  |
| PULSE |  |  |  |
| LUNGS |  |  |  |
| ABDOMEN |  |  |  |
| GENITALIA (MALES ONLY) |  |  |  |
| SKIN |  |  |  |
| MUSCULOSKELETAL |  |  |  |
| NECK |  |  |  |
| BACK |  |  |  |
| SHOULDER/ARM |  |  |  |
| ELBOW/FOREARM |  |  |  |
| WRIST/HAND |  |  |  |
| HIP/THIGH |  |  |  |
| KNEE |  |  |  |
| LEG/ANKLE |  |  |  |
| FOOT |  |  |  |

CLEARANCE

\_\_\_ CLEARED

\_\_\_ CLEARED AFTER COMPLETING EVALUATION/REHABILITATION FOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ NOT CLEARED FOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REASON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINTED OR STAMPED)

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, MD OR DO

ATHLETES NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN’S HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

LIST ALL MEDICATIONS YOU TAKE AND THE REASON FOR TAKING THEM:

1.

2.

3.

4.

LIST ANY DRUGS, FOOD OR AIRBORNE ALLERGIES YOU HAVE:

1.

2.

3.

4.

LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD:

1.

2.

3.

4.

LIST WHETHER YOU WEAR CORRECTIVE LENSES, CONTACTS, BRACES, RETAINERS OR OTHER APPLIANCES:

1.

2.

3.

4.