



SPORTS PHYSICAL EXAMINATION / HEALTH SCREENING

Student's Name: _____ **DOB:** _____

School: _____ **Sport:** _____

Last Eye Exam: _____ Last Hearing Test: _____ Last Dental Exam: _____

Are you current on all of your immunizations? Yes No Don't Know

Have you had a medical illness or injury since your last check-up or sports physical? _____

Have you ever been told by a physician that you have a heart murmur or any other cardiac condition? _____

Does anyone in your family have a history of premature, sudden cardiac death? _____

Do you have a family history of heart disease in any of your relatives less than 50 years old? _____

Do you have any allergies? _____

Are you taking any medications? _____

Please check any of the following injuries you have had in the past:

<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
<input type="checkbox"/> Upper Arm		<input type="checkbox"/> Foot

If you checked any of the injuries, please explain: _____

Please check any of the following conditions you may have experienced in the past, or that you are currently experiencing:

- High blood pressure
- Unexplained fatigue
- Syncope/near-syncope (fainting spells)
- Excessive/unexplained exertional shortness of breath
- Exertional chest pain

If you checked any of these conditions, please explain: _____

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

Parent or Athlete Signature: _____ Date: _____