**PC Cougars Sports Physical Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F Date of Birth: \_\_\_/\_\_\_/\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daytime phone, pager, cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daytime, phone, Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daytime phone: \_\_\_\_\_\_\_\_\_\_

Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Athletes and parents: This health record is a critical element in the determination of an athlete’s risk of injury in sports.

Please take the time to read and answer all questions before seeing a physician for the athlete’s physical examination.

1. Has anyone in the athlete’s family (grandparents, mother, father, brother, sister, aunt, **YES/ NO Don’t Know**

**Uncle) died suddenly before age 50?**

2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? **YES /NO Don’t Know**

3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? **YES/ NO Don’t Know**

4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? **YES/ NO Don’t Know**

5. Does the athlete have a history of concussion (getting knocked out)? **YES/ NO Don’t Know**

6. Has the athlete ever suffered a heat-related illness (heat stroke)? **YES/ NO Don’t Know**

7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem**? YES/ NO Don’t Know**

8. Does the athlete take any medication(s**)? YES/ NO Don’t Know**

9. Is the athlete allergic to any medications or bee stings? YES NO Don’t Know

10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries) **YES/ NO Don’t Know**

11. Has the athlete had an injury in the last year that caused the athlete to miss 3 or **more YES/ NO Don’t Know**

Consecutive days of practice or competition? **YES/ NO Don’t Know**

12. Has the athlete had surgery or been hospitalized in the past year? **YES/ NO Don’t Know**

13. Has the athlete missed more than 5 consecutive days of participation in usual activities **YES/ NO Don’t Know**

Because of illness, or has the athlete had a medical illness diagnosed that has not been

Resolved in the past year?

14. Are you, the athlete, worried about any problem or condition at this time**? YES/ NO Don’t Know**

Please give details on any “YES” answer from the above health history.

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 **PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN**

Height \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_ Pulse \_\_\_\_\_\_\_\_\_\_ Blood Pressure \_\_\_\_\_\_\_\_\_\_

Vision: R \_\_\_\_\_ / \_\_\_\_\_ uncorrected R \_\_\_\_\_ / \_\_\_\_\_ corrected L \_\_\_\_\_ / \_\_\_\_\_ uncorrected L \_\_\_\_\_ / \_\_\_\_\_ corrected

**Normal Abnormal Findings Initials**

1. Eyes\_\_\_\_\_\_\_\_\_\_\_\_

2. Ears, Nose, Throat\_\_\_\_\_\_\_\_

3. Mouth & Teeth\_\_\_\_\_\_\_\_\_\_

4. Neck\_\_\_\_\_\_\_\_\_\_

5. Cardiovascular\_\_\_\_\_\_\_\_\_\_

6. Chest & Lungs\_\_\_\_\_\_\_\_\_\_

7. Abdomen\_\_\_\_\_\_\_\_\_\_\_

8. Skin\_\_\_\_\_\_\_\_\_\_\_\_

9. Genitalia-Hernia (male)\_\_\_\_\_\_\_\_\_\_\_

10. Musculoskeletal: ROM, strength, etc.\_\_\_\_\_\_\_\_\_\_

11. neck\_\_\_\_\_\_\_\_\_\_\_

12. spine\_\_\_\_\_\_\_\_\_\_\_

13. shoulders\_\_\_\_\_\_\_\_\_

14. arms/ hands\_\_\_\_\_\_\_\_\_

15. hips\_\_\_\_\_\_\_\_\_\_

16. thighs\_\_\_\_\_\_\_\_\_\_

17. knees\_\_\_\_\_\_\_\_\_\_

18. ankles\_\_\_\_\_\_\_\_\_\_

19. feet\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. Neuromuscular\_\_\_\_\_\_\_\_\_\_

**Please Print/ Stamp**

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that

I am a licensed medical physician, physician’s assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is

Not satisfactory.)

Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_

**PARTICIPATION RESTRICTIONS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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