

Physical Evaluation

Name: _____ Sex: _____ Age: _____ Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Personal/Family Physician: _____ City/State: _____ Phone: _____

Medical History (Explain "yes" answers below. Circle questions you do not know the answer to.)

- | | | | | | |
|--|-----|----|--|-----|----|
| 1. Have you had a medical illness or injury in the last 5 years? | Yes | No | 17. Have you ever had a head injury or concussion? | Yes | No |
| 2. Do you have problems with your eyes, ears, nose or throat? | Yes | No | 18. Have you ever had a seizure? | Yes | No |
| 3. Do you wear corrective lenses? | Yes | No | 19. Do you have frequent or severe headaches? | Yes | No |
| 4. Do you have an ongoing chronic illness? | Yes | No | 20. Have you ever been knocked out, become unconscious or lost your memory? | Yes | No |
| 5. Have you ever been hospitalized overnight? | Yes | No | 21. Have you had any problems with your eyes or vision? | Yes | No |
| 6. Have you ever had surgery? | Yes | No | 22. Do you wear glasses, contacts or protective eyewear? | Yes | No |
| 7. Are you currently taking any prescription or non-prescription (over-the counter) medications? | Yes | No | 23. Have you ever had a sprain, strain or swelling after injury? | Yes | No |
| 8. Do you have any allergies (i.e. pollen, medicine, food, animals, or stinging insects)? | Yes | No | 24. Have you broken or fractured any bones or dislocated any joints? | Yes | No |
| 9. Do you have seasonal allergies that require medical treatment? | Yes | No | 25. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | Yes | No |
| 10. Do you have asthma? | Yes | No | 26. Have you ever had sleep disorders (i.e. pauses in breathing while asleep, daytime sleepiness, loud snoring)? | Yes | No |
| 11. Do you cough, wheeze or have trouble breathing during or after activity? | Yes | No | 27. Have you ever had diabetes or elevated blood sugar? | Yes | No |
| 12. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus or blisters)? | Yes | No | 28. Have you ever had numbness or tingling in your arms, hands, legs or feet? | Yes | No |
| 13. Have you ever had racing of your heart or skipped heartbeats? | Yes | No | 29. Do you frequently consume alcohol? | Yes | No |
| 14. Have you had high blood pressure or high cholesterol? | Yes | No | 30. Do you use narcotic or habit forming drugs? | Yes | No |
| 15. Have you ever been told you have a heart murmur? | Yes | No | | | |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | Yes | No | | | |

Explain "Yes" answers here:

Physical Examination

Name: _____ Date of Birth: ____ / ____ / ____

Height: _____ Weight: _____ % Body Fat: _____ Pulse: _____

Blood Pressure: _____ / _____ (_____ / _____ , _____ / _____)

Visual Acuity: Right 20/ _____ Left 20/ _____ Corrected: Yes | No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance	_____	_____
Eyes/Ears/Nose/Throat	_____	_____
Lymph Nodes	_____	_____
Heart	_____	_____
Pulses	_____	_____
Lungs	_____	_____
Abdomen	_____	_____
Genitalia (males only)	_____	_____
Skin	_____	_____
MUSCULOSKELETAL		
Neck	_____	_____
Back	_____	_____
Shoulder/Arm	_____	_____
Elbow/Forearm	_____	_____
Wrist/Hand	_____	_____
Hip/Thigh	_____	_____
Knee	_____	_____
Leg/Ankle	_____	_____
Foot	_____	_____

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

_____ **Cleared without limitation**

_____ **Not cleared for:** _____

_____ **Reason:** _____

_____ **Cleared after completing evaluation/rehabilitation for:** _____

_____ **Referred to:** _____

_____ **For:** _____

Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ **Date:** ____ / ____ / ____

Address: ____ 3515 Richmond Road, Texarkana, TX 75503 ____ 4701 W. 7th Street, Texarkana, TX 75501 ____ 1509 W. Loop 281, Longview, TX 75605

Signature of Physician/Physician Assistant/Nurse Practitioner _____