

STUDENT ID NUMBER: _____



SOUTHERN UNION PRE – PARTICIPATION PHYSICAL FORM

NAME: _____ SPORT: _____

DATE OF BIRTH: ____/____/____ AGE: _____ RACE: _____ SEX: _____

MEDICAL HISTORY: Please answer all of the following questions by checking “YES” or “NO”. Explain any “YES” answers in the space provided.

	YES	NO	IF “YES” USE SPACE TO EXPLAIN
1			Are you currently under a doctor’s care? If so, who? Why?
2			Any chronic or recurrent illnesses? (Diabetes, asthma, ulcer, bronchitis, sickle cell anemia)
3			Any hospitalizations?
4			Any illnesses requiring bed rest of 1 week or longer?
5			Any surgery?
6			Any surgery advised and not taken?
7			Presently taking any medications?
8			Allergic to any medications (aspirin, penicillin)?
9			Allergic to any food or insect?
10			Ever had any of the following symptoms of heart problems?
			Chest pains
			High blood pressure
			Close relative under 40 die of heart disease
11			Any dizziness, fainting, convulsions, or frequent headache?
12			Ever been “knocked out” or had a concussion? When?
13			Wear eyeglasses or contact lens?
14			Any serious eye injuries?
15			Wear any dental appliance (braces, retainer, bridge, plates)?
16			Ever suffered heat problem?
17			Ever had mononucleosis? If so, month/year.
18			Any history of enlarged spleen or liver?
19			Any organ missing other than tonsils (appendix, eye, kidney, spleen, testicle)?
20			Any history or collapsed lung or tuberculosis?
21			Any knee injury?
22			Any ankle injury?
23			Any neck injury?
24			Any other joint sprains or dislocations (shoulder, wrist, finger, and back)?
25			Any broken bones (fractures)?
26			Any known reason why this individual should not participate?

DESCRIBE ANY “YES” ANSWERS IN DETAIL IN THE SPACE BELOW. ENTER QUESTION NO. BEFORE EACH COMMENT.

CONSENT TO EXAMINATION: I, _____, hereby authorize East Alabama Orthopedic and Sports Medicine and Southern Union Sports Medicine to administer a pre-season physical examination to _____, a minor. I hereby release East Alabama Orthopedic and Sports Medicine and Southern Union Sports Medicine, its officers, directors, staff, employees, and agents for any and all liability which may arise from this consent whether or not foreseen at present.

Witness

Parent or Legal Guardian

Witness

Date

All statements answered in this record are true to the best of my knowledge. I have no abnormality, limitations, or restriction not mentioned in this record. I understand that this information is used to help determine my fitness to participate in athletics.

Date: _____

Signature: _____

STUDENT ID NUMBER: _____



ORTHOPAEDIC EXAMINATION

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE COLUMN	DESCRIBE EVERY ABNORMALITY IN DETAIL Enter pertinent item # before each comment.
		1. Neck	
		A. Impingement signs	
		B. Compression test	
		C. Strength	
		2. Back	Scoliosis Lordosis Kyphosis
		3. Upper Extremity	
		A. Shoulder	
		B. Elbow	
		C. Wrist	
		D. Hands	
		4. Lower Extremity	
		A. Hips	
		B. Knees	Quad Measurements 6" P: R: L:
		- Valgus	
		- Varus	
		- Lachman	
		- Pivot Shift	
		- A/P Drawer	
		- Hamstrings	
		C. Ankle	Achilles flex: 0 – 9° 10 – 19° 20°+
		- Inversion Stress	
		- Eversion Stress	
		- Side-to-side Talus Movement	
		- Anterior Drawer	
		D. Feet	

RECOMMENDATIONS:

PHYSICAL EXAMINATION

Height: _____ Pulse: _____ Urine Glucose: _____
 Weight: _____ B/P: _____ Urine Protein: _____
 Temp: _____ Urine Blood: _____

Visual Acuity: (Corrected) (Uncorrected) R: _____ L: _____

GENERAL MEDICAL EXAMINATION

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE COLUMN	DESCRIBE EVERY ABNORMALITY IN DETAIL Enter item # before each comment
		1. HEENT	
		2. Neck	
		3. Chest	
		4. CV	
		5. ABD.	
		6. GU	
		7. Hernia	
		8. Neuro	
		9. Skin	

This athlete (MAY) (MAY NOT) compete in athletics based on the data gathered by this examination.

_____, M.D. DATE: _____