

WBU MEDICAL HISTORY/PHYSICAL EXAMINATION FORM FOR RETURNING ATHLETES

Date of Examination: _____ Sport(s): _____

Name: _____ DOB: _____ Sex: Female / Male Classification: Fr. Soph. Jr. Sr.

MEDICAL HISTORY: If needed, use a separate sheet of paper to explain "Yes" answers.

1. Have you had any major illness or injuries since last season (i.e., hospitalized, fractures, etc.?) Yes _____ No _____
If "Yes", explain: _____
2. Have you been injured since your last physical or are you currently bothered by an injury? Yes _____ No _____
If "Yes", explain: _____
3. Have you ever had a heat injury (heat exhaustion?) Yes _____ No _____
If "Yes", explain: _____
4. Have you had a concussion since last season? Yes _____ No _____
If "Yes", explain: _____
5. Is there a history of sudden/unexpected death in any family member less than 50 years of age? Yes _____ No _____
If "Yes", explain: _____
6. Have you ever passed out with exercise? Yes _____ No _____
If "Yes", explain: _____
7. Have you had any unusual chest pain/discomfort with exercise? Yes _____ No _____
If "Yes", explain: _____
8. Have you had any unusual/excessive breathing problems with exercise? Yes _____ No _____
If "Yes", explain: _____
9. Have you ever been told to give up sports for health reasons? Yes _____ No _____
If "Yes", explain: _____
10. Please list all medications that you are currently taking:
A. _____ B. _____ C. _____ D. _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision: R 20/____ L 20/____ Corrected: Glasses/Contacts Pupils: Equal _____ Unequal _____

Medical	Normal	Abnormal Findings	Initials*
Lungs			
Eyes/Ears/Nose/Throat			
Heart/Pulse			
Abdomen			
Skin			
Neck/Spine			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Ankle/Foot			
Back			
Genitalia (males only)			

***Station-based examination only**

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

_____ Not Cleared for: _____ Reason: _____

RECOMMENDATIONS: _____

The following information must be signed by either a physician, a physician assistant licensed by a State Board of Physician Assistant Examiners, or a registered nurse recognized as an Advanced Practice Nurse by the board of Nurse Examiners.

Signature of Physician: _____ Date: _____