TACOMA BAPTIST SCHOOLS
Physical History & Examination Form

Name:_____ Birth Date:_____ Exam Date:_____
Last First
Address:_____ City:_____ ZIP:_____

History – Please circle YES or NO

1 ***Y*** ***N*** Have you had any illness/injury recently, or do you have illness/injury now?
- a. ***Y*** ***N*** Have you had a medical problem, illness or injury since your last exam?
- b. ***Y*** ***N*** Do you have a chronic or recurrent illness?
- c. ***Y*** ***N*** Have you ever had any illness lasting more than a week?
- d. ***Y*** ***N*** Have you ever been hospitalized overnight?
- e. ***Y*** ***N*** Have you had any surgery other than tonsillectomy?
- f. ***Y*** ***N*** Have you ever had any injuries requiring treatment by a physician?
- g. ***Y*** ***N*** Do you have any organ missing other than tonsils? (appendix, eye, kidney, etc.)?

2 ***Y*** ***N*** Are you presently taking ANY medications (including birth control pills, vitamins, aspirin, etc.)?

3 ***Y*** ***N*** Do you have ANY allergies (medicines, bees, foods, or other factors)?

4 ***Y*** ***N*** Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
- a. ***Y*** ***N*** Do you tire more easily or quickly than your friends during exercise?
- b. ***Y*** ***N*** Have you ever had any problems with your blood pressure or your heart?
- c. ***Y*** ***N*** Have any close relatives had heart problems, heart attack, or sudden death before they were age 50?

5 ***Y*** ***N*** Do you have any skin problems (acne, itching, rashes, etc.)?

6 ***Y*** ***N*** Have you ever had fainting, convulsions, seizures or severe dizziness?
- a. ***Y*** ***N*** Do you have frequent severe headaches?
- b. ***Y*** ***N*** Have you ever had a "stinger" or a "burner" or a "pinched nerve"?
- c. ***Y*** ***N*** Have you ever been "knocked out" or "passed out"?
- d. ***Y*** ***N*** Have you ever had a neck or head injury?

7 ***Y*** ***N*** Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?

8 ***Y*** ***N*** Have you had asthma, or trouble breathing, or cough during or after exercise?

9 ***Y*** ***N*** Do you wear eyeglasses, contact lenses or protective eye wear?
- a. ***Y*** ***N*** Have you had any problem with your eyes or vision?

10 ***Y*** ***N*** Do you wear any dental appliance such as braces, bridge, plate, or retainer?

11 ***Y*** ***N*** Have you ever had a knee injury?
- a. ***Y*** ***N*** Have you ever had an ankle injury?
- b. ***Y*** ***N*** Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
- c. ***Y*** ***N*** Have you ever had a broken bone (fracture)?
- d. ***Y*** ***N*** Have you ever had a cast, splint, or had to use crutches?
- e. ***Y*** ***N*** Must you use special equipment for competition (pads, braces, neck roll, etc.)?

12 ***Y*** ***N*** Has it been more than 5 years since your last tetanus booster shot?

13 ***Y*** ***N*** Are you worried about your weight?

14 ***Y*** ***N*** FEMALES: Have you had any menstrual problems?

15 ***Y*** ***N*** Have you any medical concerns about participating in your sport?

*********ATHLETE SHOULD NOT WRITE BELOW THIS LINE*********

Examiner's comments on all "YES" answers (refer to question number):

_____
_____
_____
_____
_____

TACOMA BAPTIST SCHOOLS
Physical Examination Form – Page 2

Name:_____
Last First

Age:_____ Pulse:_____ Optional:
Body Fat %: _____

Height:_____ Blood Pressure:_____ HCT: _____
EST V02 Max:_____

Weight:_____ Visual Acuity: Left 20/_____ Audiometry:_____
Right 20/_____

Normal:			Abnormal:	Notes:
_____	1	Head	_____	_____
_____	2	Eyes (pupils), ENT	_____	_____
_____	3	Teeth	_____	_____
_____	4	Chest	_____	_____
_____	5	Lungs	_____	_____
_____	6	Heart	_____	_____
_____	7	Abdomen	_____	_____
_____	8	Genitalia	_____	_____
_____	9	Neurologic	_____	_____
_____	10	Skin	_____	_____
_____	11	Physical Maturity	_____	_____
_____	12	Spine, Back	_____	_____
_____	13	Shoulders, Upper Extremities	_____	_____
_____	14	Lower Extremities	_____	_____

Assessment: _____Full Participation
_____Limited participation (describe limitations, restrictions):

_____

_____

_____Participation contraindicated (list reasons):

_____

_____

Recommendations (equipment, taping, rehabilitation, etc.):

_____

_____

Examiner's Signature: Exam Date:

Print Examiner's Name: Examiner's Phone: