PHYSICAL EVALUATION FORM

Name ____ Date of **Exam** ____________________________

Date of **Birth** ______________________ Sport(s) ____

Explain "Yes" answers. Circle questions you don't know the answers to. Circle One

		Circle One	
1.	Have you had a medical illness or injury since your last checkup or sports physical? If yes, was any rehabilitation required?	Yes	No
2.	Do you have an ongoing or chronic illness?	Yes	No
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	Yes	No
4.	Have you ever passed out during or after exercise?	Yes	No
5.	Have you ever been dizzy during or after exercise?	Yes	No
6.	Have you ever had chest pain during or after exercise?	Yes	No
7.	Has any family member or relative died of heart problems or of sudden death before age 50?	Yes	No
8.	Has a physician ever denied or restricted your participation in sports for any reason?	Yes	No
9.	Have you ever had racing of your heart or skipped heartbeats?	Yes	No

EXPLAIN "YES" ANSWERS HERE:

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete________________________Signature of Parent/Guardian________________________Date_________

Reviewed by: ____MD/DO