

# WHATCOM COUNTY SPORTS PHYSICAL EXAM

(Required prior to participation in Middle & High Schools – PARENTS MUST REVIEW & SIGN)

- Pre-Participation  
 Returning

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ School \_\_\_\_\_ Exam Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Parent's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Sport (s) \_\_\_\_\_

In case of emergency contact: Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

## MEDICAL HISTORY

Yes/No (to be completed by student & parents/guardians)

- Y N 1. Have you had any illness/injury recently or now?
- Y N 2. Have you had a medical problem, illness or injury since your last exam?
- Y N 3. Do you have any chronic or recurrent illness?
- Y N 4. Have you ever had an illness lasting more than a week?
- Y N 5. Have you ever been hospitalized overnight?
- Y N 6. Have you had any surgery?
- Y N 7. Have you ever had any injuries requiring treatment by a physician?
- Y N 8. Do you have any organs missing? (appendix, eye, kidney, testicle, etc.)
- Y N 9. Are you presently taking **any** medications? (including vitamins, aspirin)
- Y N 10. Do you have **any** allergies? (medicine, bees, foods)
- Y N 11. Have you ever had chest pain, dizziness, fainting, or passing out during or after exercise?
- Y N 12. Do you tire more easily or quickly than your friends during exercise?
- Y N 13. Have you ever had any problem with your blood pressure or your heart?
- Y N 14. Have any close relatives had heart problems, heart attacks, or sudden death **before** they were age 50?
- Y N 15. Do you have any skin problems? (acne, itching, rashes, etc.)
- Y N 16. Have you ever had fainting, convulsions, seizures or severe dizziness?
- Y N 17. Do you have frequent severe headaches?
- Y N 18. Have you ever had a "stinger" or "burner" or "pinched nerve?"
- Y N 19. Have you ever been "knocked out" or "passed out?"
- Y N 20. Have you ever had a neck or head injury?
- Y N 21. Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?
- Y N 22. Do you have asthma, trouble breathing, or cough during or after exercise?
- Y N 23. Do you wear eyeglasses, contact lenses, or protective eyewear?
- Y N 24. Have you had any problem with your eyes or vision?
- Y N 25. Do you wear any dental appliance? (braces, bridge, plate, retainer)
- Y N 26. Have you ever had a knee or ankle injury?
- Y N 27. Have you ever injured any other joint? (shoulder, wrist, fingers, etc.)
- Y N 28. Have you ever had a broken bone? (fracture)
- Y N 29. Have you ever had a cast, splint, or had to use crutches?
- Y N 30. Must you use special equipment for competition? (braces, etc.)
- Y N 31. Has it been more than eight years since your last tetanus booster shot?
- Y N 32. Are you worried about your weight?
- Y N 33. Have you any medical concerns about participating in your sport?
- Y N 34. Are you taking any pills or drugs to increase your strength or performance?
- Y N 35. **FEMALES:** Have you any menstrual problems?

I attest, by my signature below, that to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

## PHYSICAL

(to be completed by doctor)

Age \_\_\_\_\_ Height \_\_\_\_\_

Weight \_\_\_\_\_ BP \_\_\_\_\_

Pulse \_\_\_\_\_

Vision R \_\_\_\_ / \_\_\_\_ L \_\_\_\_ / \_\_\_\_

## MEDICAL

Normal/Abnormal Findings

N A Appearance \_\_\_\_\_

N A Eyes \_\_\_\_\_

N A Ears \_\_\_\_\_

N A Nose \_\_\_\_\_

N A Throat \_\_\_\_\_

N A Heart \_\_\_\_\_

N A Lymph Nodes \_\_\_\_\_

N A Pulses \_\_\_\_\_

N A Lungs \_\_\_\_\_

N A Abdomen \_\_\_\_\_

N A Genitalia (males only) \_\_\_\_\_

N A Skin \_\_\_\_\_

## MUSCULOSKELETAL

N A Neck \_\_\_\_\_

N A Back \_\_\_\_\_

N A Shoulder/Arm \_\_\_\_\_

N A Elbow/Forearm \_\_\_\_\_

N A Wrist/Hand \_\_\_\_\_

N A Hip/Thigh \_\_\_\_\_

N A Knee \_\_\_\_\_

N A Leg/Ankle \_\_\_\_\_

N A Foot \_\_\_\_\_

## ASSESSMENT

Full Participation  Limited Participation

Describe limitations, restrictions \_\_\_\_\_

Participation contraindicated (list reasons) \_\_\_\_\_

Recommendations (equipment, taping, rehabilitation, referral) \_\_\_\_\_

Examiner's Name \_\_\_\_\_

Signature \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_