Physical Evaluation

Name:_____ Sex: ____ Age: _____ Date of Birth:_____/_____/_____

Address:_____

City: _____ State: _____ Zip Code: _____ Phone:_____

Emergency Contact: _____ Phone: _____

Personal/ Family Physician: _____ City/State: _____

Physician Phone: _____

Medical History (Explain "Yes" answers below. Mark an "X" next to your appropriate answer.)

1. Have you ever had a medical injury in the last 5 years? _Yes ___No
2. Do you have Problems with your eyes? _Yes ___No
3. Do you wear corrective lenses? _Yes ___No
4. Do you have an ongoing chronic illness? _Yes ___No
5. Have you ever been hospitalized overnight? __Yes ___No
6. Have you had surgery? __Yes ___No
7. Are you currently taking any prescription or Non-prescription (over the counter) medications? _Yes ___No
8. Do you have any allergies (i.e. pollen, food, medicine, animals, insects?) __Yes ___No
9. Do you have seasonal allergies that require medical treatment? __Yes ___No
10. Do you have asthma?
11. Do you cough, wheeze, or have trouble breathing during or after activity? __Yes ___No
12. Do you have any current skin problems? (i.e. itching, rashes, acne, warts, fungus, blisters?) __Yes ___No
13. Have you ever had racing of your heart or skipped heartbeats? __Yes ___No
14. Have you had high blood pressure or high cholesterol? ___Yes ___No
15. Have you ever been told you have a heart murmur? ___Yes ___No
16. Has any family member or relative died of heart problems or sudden death before age 50? ___Yes ___No
17. Have you ever had a head injury or concussion? ___Yes ___No
18. Have you ever had a seizure? ___Yes ___No
19. Do you have frequent severe headaches? ___Yes ___No
20. Have you ever been knocked out, become unconscious or lost your memory? ___Yes ___No
21. Have you had any problems with your eyes or vision? ___Yes ___No
22. Do you wear corrective lenses? ___Yes ___No
23. Have you had a sprain, strain or swelling after an injury? ___Yes ___No
24. Have you broken or fractured any bones or dislocated any joints? ___Yes ___No
25. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? ___Yes ___No
26. Have you ever had sleep disorders? (i.e. pauses in breathing while asleep, daytime sleepiness, loud snoring?) ___Yes ___No
27. Have you ever had diabetes or elevated blood sugar? ___Yes ___No
28. Have you ever had numbness or tingling in your arms, legs, hands, or feet? ___Yes ___No
29. Do you frequently consume alcohol? ___Yes ___No
30. Do you use narcotic or habit forming drugs? ___Yes ___No

Explain "**YES**" answers here:

_____

_____

_____