

**CHABOT COLLEGE ATHLETICS
PHYSICAL EXAMINATION FORM**

Name (Last, First): _____ Sport: _____

Birthdate: _____ Social Security No.: _____

GENERAL: Height: _____ Weight: _____ Body Fat %: _____

Blood Pressure: _____ Pulse: _____

EXAMINATION:

Eyes: Uncorrected	Corrected	
Rt. 20 / _____	Rt. 20 / _____	Glasses _____
Lt. 20 / _____	Lt. 20 / _____	Contacts _____

Lungs / Chest: _____ Heart: Murmurs _____ Rhythm _____

Abdomen: Spleen _____ Liver _____ Other _____

Genitalia: _____

Neurological: Biceps _____ Triceps _____ Patellar _____ Achilles _____

ORTHOPEDIC:

Neck _____ Back _____ Ribs _____

Shoulder _____ Elbow _____ Wrist / Hand _____

Hip _____ Knee _____ Foot / Ankle _____

URINALYSIS:

pH _____ Blood _____ Protein _____ Ketones _____ Glucose _____

COMMENTS / RECOMMENDATIONS: _____

PARTICIPATION STATUS:

Full _____ Limited _____ None _____ Requires _____

Physician Signature: _____ **Phone:** _____

Place Stamp Here:

MEDICAL HISTORY

Please provide the following information and include: Date(s), L/R, Doctor Names, etc

PAST INJURIES

Comments:

Concussions?	Yes ___ No ___	_____
Facial Injuries	Yes ___ No ___	_____
Neck Injuries?	Yes ___ No ___	_____
Back Injuries?	Yes ___ No ___	_____
Chest/Rib Injuries?	Yes ___ No ___	_____
Shoulder Injuries?	Yes ___ No ___	_____
Elbow Injuries?	Yes ___ No ___	_____
Wrist/Hand/Finger Injuries?	Yes ___ No ___	_____
Hip Injuries?	Yes ___ No ___	_____
Knee Injuries?	Yes ___ No ___	_____
Ankle Injuries?	Yes ___ No ___	_____
Foot Injuries?	Yes ___ No ___	_____
Hernia?	Yes ___ No ___	_____
Broken Nose?	Yes ___ No ___	_____

PAST ILLNESSES / MEDICAL CONDITIONS

Pneumonia?	Yes ___ No ___	_____
Rheumatic / Scarlet Fever?	Yes ___ No ___	_____
Heart Murmur?	Yes ___ No ___	_____
Diabetes?	Yes ___ No ___	_____
Drug Allergies?	Yes ___ No ___	_____
Food Allergies?	Yes ___ No ___	_____
Asthma?	Yes ___ No ___	_____
Skin Disorders?	Yes ___ No ___	_____
Kidney Disorders?	Yes ___ No ___	_____
Fainting?	Yes ___ No ___	_____
Convulsive Disorder?	Yes ___ No ___	_____
Epilepsy?	Yes ___ No ___	_____
Ulcers?	Yes ___ No ___	_____
Mono?	Yes ___ No ___	_____
Sudden death in family?	Yes ___ No ___	_____
Any surgeries (list)?	Yes ___ No ___	_____
Any medications (type)?	Yes ___ No ___	_____

IMMUNIZATIONS (dates): Tetanus _____ Tuberculosis _____

I verify that all information listed is accurate:

Athletes Signature: _____ Date: _____

Parent's Signature (if athlete is under 18 years of age): _____