Athletic Physical Examination

This form was developed in accordance with the NCAA Sports Medicine Guidelines and the AHA Recommendation for Cardiovascular Preparticipation Screening of Competitive Athletes.

Name: __________________________________________ Date of Exam: ______________________

Date of Birth: __________ Age: ___ Sex: ___ Sport: ___________________________________________

Height (inches): _______ Weight (lbs.): _______ Brachial Blood Pressure (sitting position): _______ Pulse: _______

Vision: Right 20/____ Left 20/____ Contact Lens: ❑ Yes ❑ No ☐ Color Blind: ❑ Yes ❑ No

Hearing: (whispered voice at 10 feet) Right: ❑ Normal ❑ Abnormal Left: ❑ Normal ❑ Abnormal

Clinical Evaluation

Normal ❑ Abnormal ❑ NOTES (Describe any abnormality in detail. Include results of any lab done.)

1. Scalp, Face, Neck, Thyroid
2. Nose and Sinuses
3. Mouth (tongue, gingivae, teeth)
4. Throat and Tonsils
5. Ears (tymns and ext. canals)
6. Eyes (pupils, EOM conjunct.)
7. Lungs and Chest (include breasts)
8. Heart (rhythm, sounds, murmurs)
   a. Precordial auscultation (supine) (standing)
   b. Assessment of femoral artery pulses (to exclude coarctation of the aorta)
   c. Physical stigmata of Marfan syndrome

9. Abdomen and Viscera
10. Hernia
11. Anus and Rectum (prostate if indicated)
12. Endocrine system
13. G-U System
14. Upper Extremity (shoulder, arm, wrist, hand)
15. Lower Extremity (hip, thigh, knee, ankle, foot)
16. Skin, Lymphatic Glands (cervical, inguinal, axillary)
17. Neurologic
18. Pelvic (if deemed necessary) Menstrual Cycle
19. Surgery(ies)
20. Other

Drug Allergies, Medications currently prescribed, etc.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

(over)
Physician Recommendation

Please Complete

1. ☐ Approved for athletic participation without limitation.

2. ☐ Approved for athletic participation with limitation.
   Specify: __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

3. ☐ NOT approved for athletic participation.
   Specify: _________________________________________________________
   __________________________________________________________
   __________________________________________________________

Printed Name of Physician: ____________________________
Clinic Name/Facility: ________________________________
Street/City/State/Zip: ________________________________
Phone: __________________________ Fax: ______________________
Signature of Physician: ___________________________ Date _____________________
Medical License #: _________________________________

This form must be signed by an MD or DO.