

# UNOH Physical 2011-2012

Name \_\_\_\_\_ Sex \_\_\_\_\_ Sport \_\_\_\_\_  
(First, Middle Initial, Last)

SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Local (UNOH) Address \_\_\_\_\_ Phone \_\_\_\_\_  
Dorm / Street

\_\_\_\_\_ Cell Phone \_\_\_\_\_  
City State Zip

UNOH Email Address \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS IN AS MUCH DETAIL AS POSSIBLE.  
Please check the appropriate box. Please comment on all yes answers.**

<b>Have you had:</b>	<b>Y N</b>	<b>Comments (If YES, please explain)</b>
A severe viral infection in the last month? (e.g. mono)	( ) ( )	_____
 <b>Have you ever:</b>		
Had a physician deny or restrict your participation in sports for any reason??	( ) ( )	_____
Been hospitalized overnight?	( ) ( )	_____
Had any surgery?	( ) ( )	_____
 <b>Has anyone in your immediate family ever had:</b>		
Sudden death (age less than 50)?	( ) ( )	_____
Heart attack (age less than 50)?	( ) ( )	_____
Marfan syndrome?	( ) ( )	_____
Sickle cell disease or trait?	( ) ( )	_____
 <b>Have you ever had or do you now have:</b>		
Chest pain with or after exercise?	( ) ( )	_____
High blood pressure?	( ) ( )	_____
Heart problems?	( ) ( )	_____
Passed out with exercise?	( ) ( )	_____
Test for your heart? (ECG etc.)	( ) ( )	_____
Epilepsy?	( ) ( )	_____
Convulsions or seizures?	( ) ( )	_____
Diabetes?	( ) ( )	_____
Asthma, Wheezing/cough with exercise?	( ) ( )	_____
Anemia?	( ) ( )	_____
Hearing loss or perforated eardrum?	( ) ( )	_____
Severe headaches or migraines?	( ) ( )	_____
Sickle cell disease or trait?	( ) ( )	_____
Other ongoing medical condition?	( ) ( )	_____
Impaired vision, wear glasses/contacts?	( ) ( )	Glasses / Contacts / Both (please circle)
Heat exhaustion or heat intolerance?	( ) ( )	_____
Frequent anxiety, depression, insomnia?	( ) ( )	_____
Hernia?	( ) ( )	_____
Loss of function or absence of any organ such as testicle, kidney, eye?	( ) ( )	_____
Eating disorder?	( ) ( )	_____
Do you use weight loss meds, laxatives?	( ) ( )	_____
 <b>Have you in the past, or do you currently use:</b>		
Supplements (including creatine)?	( ) ( )	_____

**List any current medications you are taking (including over the counter medications and inhalers):**  
\_\_\_\_\_

List any allergies: \_\_\_\_\_

<b>Have you ever had:</b>	<b>Y N</b>	<b>Comments (If YES, please explain)</b>
Loss of consciousness?	( ) ( )	_____
A Concussion?	( ) ( )	_____
How many concussions? _____		

Date of most recent \_\_\_\_\_

**Have you ever had a neck injury of any kind?** ( ) ( )  
If yes, Explain \_\_\_\_\_

**Have you ever had a back injury?** ( ) ( )  
If yes, Explain \_\_\_\_\_

**Have you ever sustained a shoulder injury? R or L?** ( ) ( )  
If yes, Explain \_\_\_\_\_

**Have you ever sustained a knee injury? R or L?** ( ) ( )  
If yes, Explain \_\_\_\_\_

**Have you had any other injury to a joint, bone, or muscle that you had to see a Doctor for?** ( ) ( )  
If yes, Explain \_\_\_\_\_

**Do you regularly use a brace or assistive device?** ( ) ( ) \_\_\_\_\_

**Have you ever been treated for a mental condition or are you currently under the care of a mental health professional?** ( ) ( ) \_\_\_\_\_

Have you been prescribed any medications by a mental health professional? If Yes, specify what. \_\_\_\_\_

**Do you have any other medical or physical condition not mentioned?** ( ) ( )  
Explain. \_\_\_\_\_

**Females**

Have you had or do you now have menstrual irregularities or absence of menses? ( ) ( ) \_\_\_\_\_

Longest time between periods in last year. \_\_\_\_\_

Age at first period? \_\_\_\_\_

Last menstrual period? \_\_\_\_\_

**I attest that the above information is correct and complete to my knowledge.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICAL EXAMINATION**  
**(To be completed by physician)**

Date \_\_\_\_\_ Name \_\_\_\_\_ Sport \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Vision: R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected Yes / No

	<b>Nml</b>	<b>Abnml</b>	<b>Comments</b>
HEENT	( )	( )	_____
Cardiac	( )	( )	_____
Lungs	( )	( )	_____
Skin	( )	( )	_____
Abdominal	( )	( )	_____
Upper Extremity Joints	( )	( )	_____
Lower Extremity Joints	( )	( )	_____
Spine & Musculature	( )	( )	_____
Genitalia (males only)	( )	( )	_____

Other:

\_\_\_\_\_

**I certify that I have reviewed the history and examined the above student and I recommend:**

**Comments**

\_\_\_\_\_ Clearance for athletic participation with no limitations. \_\_\_\_\_

\_\_\_\_\_ Clearance pending further evaluation or testing. Explain \_\_\_\_\_

\_\_\_\_\_ Referral to other health care professional prior to clearance. \_\_\_\_\_

\_\_\_\_\_ Clearance with limitations. \_\_\_\_\_

\_\_\_\_\_ Disqualified from competition. \_\_\_\_\_

(use another sheet if needed)

Name of Examining Practitioner \_\_\_\_\_

MD DO NP PA

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_

*Practitioner Stamp*

Signature \_\_\_\_\_ Date \_\_\_\_\_