

**Wheeling Jesuit University – Athletic Department
Physical Examination Form**

Name: _____ Sex: _____ M _____ F _____
Last First Middle

Home Address: _____
Street City State Zip

Social Security #: _____ Date of Birth: _____ Sport(s): _____

Person to be notified in Emergency: _____

Address Telephone Number Relationship

Name of Family Physician: _____
Address Telephone Number

PERSONAL HISTORY – The information requested below will be used only as an aid in the consideration of your health needs and will remain confidential between the Health Center, Counseling Center, and Athletic Training Room, if so applicable.

Are you presently under any medical treatment? Yes No

If yes, explain: _____

Are you taking any medications at present (prescription, nonprescription, inhaler)? Yes No

If yes, explain: _____

Are you now receiving or have you ever received professional help for problems of an emotional or psychological nature? If so, when: Yes No

Do you have a physical impairment such as paralysis, loss of vision, hearing, etc.? Yes No

If yes, explain: _____

Do you have any sensitivity to food, medicine, or environmental contact? Yes No

If yes, explain: _____

Have you ever had a head injury or concussion? Yes No

If yes, explain and give dates: _____

Has a physician ever denied or restricted your participation in sports for any heart problems? Yes No

If yes, explain: _____

Have you ever had, or do you currently have any of the following:

- | | | |
|--|--------------------------------------|-----------------------------|
| Chicken Pox | Nervous Tendencies | Rheumatic Fever |
| Heart Disease | Mononucleosis | Tuberculosis |
| Hepatitis | Diabetes | Convulsions or “black outs” |
| Seizures | Heart Murmur | Eating Disorders |
| Heat Related Illness | Asthma, Hay Fever, or Hives | |
| Pregnancies | Date of last menstrual period: _____ | |
| Loss of function of a “paired organ” (eye, ear, testicle, ovary, kidney) | | |

Use the following space to explain any of the above marked replies: _____

Dates of significant injuries or operations or medical admissions to hospitals: _____

Personal Habits (please indicate use of any of the following):

Smoking tobacco Smokeless Tobacco Alcohol Dietary Supplements Dental appliances

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete: _____ Signature of parent/guardian: _____ Date: _____
(if under 18 years of age)

This section is to be completed by your physician.

Family history:

Among your immediate relatives (parents, siblings and grandparents), is there any history of or present illness from any of the following:

- | | | |
|---------------|------------------|---|
| Cancer | Diabetes | Asthma, Hay Fever, or other Allergies |
| Heart Disease | Marfan's Disease | Sudden death under age 50 from non-trauma cause |

Please explain any of the marked above replies: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Eye Examination: Pupils: Equal Unequal
Glasses Contact Lenses

Distant Vision: Right 20/_____ Corr. to 20/-_____
Left 20/_____ Corr. to 20/-_____

Normal	Abnormal	Notes of Abnormality
_____ Skin	_____	
_____ Hearing	_____	
_____ Head	_____	
_____ Ear, Nose, & Throat	_____	
_____ Neck: Thyroid	_____	
_____ Cardiovascular	_____	
_____ Lungs	_____	
_____ Breasts	_____	
_____ Abdomen	_____	
_____ Genitalia	_____	
_____ Menstruation	_____	
_____ Back & Extremities	_____	
_____ Reflexes	_____	

Please note allergies or sensitivities, which may be significant: _____

Please explain any physical or emotional conditions that you consider important: _____

Is this student presently under medical therapy or psychological counseling? _____

Clearance

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print/type): _____ Phone: _____

Address: _____

Signature of Physician: _____ Date: _____