

**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 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous Tendencies | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Convulsions or “black outs” |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Heat Related Illness | <input type="checkbox"/> Asthma, Hay Fever, or Hives | |
| <input type="checkbox"/> Pregnancies | Date of last menstrual period: _____ | |
| <input type="checkbox"/> 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)

