

**WAKE FOREST PEDIATRIC ASSOCIATES, PLLC
GENERAL SPORTS PHYSICAL FORM**

Patient's Name _____ Chart Number _____

Height _____ Weight _____ Sex _____ DOB _____ Grade _____

PHYSICAL EXAM:

Eyes _____	Ears _____	Nose _____
Throat _____	Teeth _____	Skin _____
Lymphatic _____	Lungs _____	Heart _____
Abdomen _____	Genitalia/Hernia _____	Peripheral pulses _____
Cervical spine/neck _____	Back _____	Shoulders _____
Arm/elbow/wrist/hand _____	knees/hips _____	Ankles/feet _____

When medically indicated:

LAB:

Urinalysis _____ Hemoglobin or HCT _____

PHYSICIAN STATEMENT:

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

_____ Full Participation _____ Limited Participation _____ No Participation _____ Needs Additional Evaluation

If not full participation give reasons & recommendations: _____

Any recommendations or concerns on such items as:

1. Weight loss or gain or restrictions of weight loss: _____
2. Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing: _____
3. Other: _____

Physician Signature _____, MD Date _____

Physician Name (print) _____, MD 1655 Wake Drive, Suite 101
Wake Forest, NC 27587
919-556-4779 (office)

MEDICAL HISTORY

This form must be completed by parent or guardian prior to the physical examination and reviewed by the physician during the examination.

Yes	No	Have you ever had any of the following?	Please explain any YES answers.
___	___	heart murmur _____	
___	___	high blood pressure _____	
___	___	other heart problems _____	
___	___	broken bones _____	
___	___	injury to joints – ankles, knees, elbows, shoulders, wrists, _____	
___	___	concussion _____	
___	___	operation _____	
___	___	seizures or epilepsy _____	
___	___	Have you ever fainted or passed out? _____	
___	___	Have you ever been knocked out? _____	
___	___	Have you ever been hospitalized? _____	
___	___	Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath? _____	
___	___	Have you ever had significant allergies to:	
___	___	Bee stings? On medication ___yes ___no _____	
___	___	foods _____	
___	___	medicine _____	
___	___	others _____	
___	___	Do you have prescription for use of:	
___	___	Inhalers _____	
___	___	Other allergy medicine _____	
___	___	Do you have asthma? _____	
___	___	Do you take any medicine regularly? _____	
___	___	Have you had any illnesses lasting a week or more such as mononucleosis, etc.? _____	
___	___	Have you had any blood disorders, including sickle cell trait, anemia, etc.? _____	
___	___	Has any family member had a heart attack, heart problems or sudden death before age 50? _____	
___	___	Do you wear contact lenses, eyeglasses or dental appliances? _____	
___	___	Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.? _____	
___	___	Have you begun menses yet? _____	
___	___	Do you have any other significant health problems? _____	
___	___	Hepatitis B Immunization Series? _____	
___	___	Date of last Tetanus Immunization? _____	

Parent/Guardian Signature _____ Date _____