

Physical Examination

Name _____ Date of Birth _____

SS# _____ Height _____ Weight _____ % Body Fat (optional _____)

Vision R 20/____ L 20/____ Corrected Y N Pulse _____ BP _____/____ (_____/_____, ____/____)
PRN BP recheck or position

Glasses Y N Contacts Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia(males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

Clearance

Cleared
 Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____
 Recommendations: _____

Name of examiner (Print/type) _____ Date: _____
 Address _____ Phone _____
 Signature of examiner _____

Modified from the form approved by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy of Sport Medicine.