James A. Taylor Student Health Service
Division of Student Affairs
The University of North Carolina at Chapel Hill

PLEASE PRINT CLEARLY

ROWING TRY-OUT PHYSICAL

NAME:_______________________________________ HOME PHONE:_______________________

AGE:_____________ DATE OF BIRTH:______ / _______ / ________

ANSWER THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE	YES	NO	DON'T KNOW	ELABORATION OF YES ANSWERS
Has anyone in your family (grandparents, parents, brothers, sisters) died before the age of 50?				
Have you ever stopped exercising because you were dizzy or have you ever passed out during exercise?				
Have you ever been told you have a heart problem?				
Do you ever experience wheezing, difficult breathing or coughing while exercising?				
Have you ever broken a bone, dislocated a joint, or had to wear a cast? List joints:				
Have you ever had a concussion, head/neck/back injury, or tingling or numbness in your arms/legs?				
Have you ever had a heat related illness (heat stroke, heat exhaustion) or had difficulty exercising in warm/hot weather?				
Do you have anything you want to talk to the doctor about?				
Do you have a chronic illness or see a doctor regularly for any particular problem?				
Are you taking any medications? List drug(s), dosage, times/day:				
Are you allergic to any medications or bee stings? List medications:				
Do you have only one of any paired organ (eyes, kidneys, testicles, ovaries, etc)				
Do you wear contacts or eye glasses?				
Do you feel you are over or under weight or are you on a special diet?				
Has a doctor ever told you to give up sports or limit your activity because of a health related problem?				

I have read and agree with my answering of the above medical history questions.

Patient Signature:_______________________________ Date:_______ / ______ / ______

A. VITAL STATISTICS:

Height: _______________ Weight: _________________ Blood Pressure: ____________________

B. MUSCULOSKELETAL EXAM:

	NORMAL	ABNORMAL	RECORD LAXITY, WEAKNESS, INSTABILITY, DECREASED ROM, OR POSITIVE TESTS
NECK			
SHOULDER			
SPINE			
HIP			
KNEE			
ANKLE			
FEET			
OTHER			

C. PHYSICIAN'S EXAM:

	NORMAL	ABNORMAL	COMMENTS
ENT			
HEART			
LUNGS			
ABDOMEN			
SKIN			
OTHER			

D. PHYSICIAN'S ASSESSMENT AND COMMENTS:

E. RECOMMENDATIONS:

1. Cleared_____________ 2. Not Cleared: _____________ 3. Plan:___________________________

F. PHYSICIAN'S SIGNATURE:

Signature:____ Date: _____/_____ / _____

Name (print): ____ Phone Number: __________________