

# FAIRMONT STATE UNIVERSITY

## HEALTH SERVICE

### ATHLETIC PHYSICAL FORM

Name: \_\_\_\_\_  
(Last) (First) (mid int.)

Age: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Birth date: \_\_\_\_\_

Exam Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent or Guardian: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Family Physician: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Sports you are playing: \_\_\_\_\_

**Have you had or do you now have, any problems with the following:**  
(check all that apply)

Scarlet Fever  
Diphtheria  
Rheumatic Fever  
Measles  
Mumps  
Chickenpox  
Whooping Cough  
Hay Fever  
Sinus problems  
Asthma  
Allergies

Mental Disease  
Paralysis  
Epilepsy  
Kidney Disease  
Heart Disease  
Pneumonia  
Tuberculosis  
Pleurisy  
Frequent Headaches  
High Blood Pressure  
Digestive Problems

(continued)

Diabetes  
Hernia  
Appendicitis  
Fainting  
Nervous Disease  
Deafness  
Acne

Shortness of Breath  
Running Ears  
Excessive Weight Loss  
Bone or Joint Disorder  
Knee Disorder  
Skin Disease  
Menstrual Difficulties

Family History of Diabetes:  
Family History of Tuberculosis:  
Family History of Mental Disorder:

Relationship to you:  
Relationship to you:  
Relationship to you:

Serious Illnesses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Operations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Broken Bones / Joint injuries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PHYSICAL EXAMINATION

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Pulse \_\_\_\_\_

Normal      Abnormal      Abnormalities below:

**Skin** \_\_\_\_\_ /

**Eyes** \_\_\_\_\_ /

Normal      Abnormal

Abnormalities below:

**Nose** \_\_\_\_\_ /

**Teeth** \_\_\_\_\_ /

**Tongue** \_\_\_\_\_ /

**Thyroid** \_\_\_\_\_ /

**Neck** \_\_\_\_\_ /

**Glands** \_\_\_\_\_ /

**Heart** \_\_\_\_\_ /

**Lungs** \_\_\_\_\_ /

**Abdomen** \_\_\_\_\_ /

**Hernia** \_\_\_\_\_ /

**Extremities** \_\_\_\_\_ /

**Reflexes** \_\_\_\_\_ /

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Practitioner: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_