WESTERN WASHINGTON FAMILY PRACTICE
SPORTS PHYSICAL O
CHILDHOOD PERIODIC EXAM O

NAME: _____ SEX: M / F DOB: _____ AGE: _____

CONCERNS: _____ SPORTS: _____

CURRENT MEDICATIONS: _____ ALLERGIES: _____

INJURIES: _____ SURGERIES: _____

MAJOR ILLNESSES: _____ LOSS OF ORGANS: _____

HISTORY: _____Diabetes _____Urinary Probs _____Musculoskeletal _____Hay fever
_____Contraception _____GI Probs _____Bleeding Disorder _____ Alcohol
_____Seizures _____Sex _____Drugs

FAMILY ILLNESSES: _____

_____

Date of Last Physical Exam: _____ ____ Date of Last Dental Exam: _____
Females Only-:
Age when first menstrual period occurred: _____ Any Menstrual Problems: _____

QUESTIONAIRE:	YES	NO	N/A
* Heart murmur, high blood pressure, extra heartbeats or any other heart problem?	O	O	O
* Chest pain or dizziness with exercise or fainting during exercise?	O	O	O
* Asthma or trouble with wheezing/breathing after strenuous exercise?	O	O	O
* Difficulty running a ½ mile (twice around the track)?	O	O	O
* Problems with heat, such as heat stroke or heat exhaustion?	O	O	O
* Problems with eyes, ears, kidneys or testicles?	O	O	O
* Ever been unconscious, knocked out or had a concussion?	O	O	O
* Any fractured/broken bones, cast/splint or crutches?	O	O	O
* Any sprains/dislocation or other injuries which caused the student See a doctor or miss a sports game/match?	O	O	O
* Any other hospitalizations (at least within the last 2wks)?	O	O	O
* Contact lenses?	O	O	O
* Dental appliances (such as braces, bridges or plates)?	O	O	O
* Has it been 10 or more years since your last Tetanus shot?	O	O	O
* Anyone in the family under the age of 50 with heart problems/ Suffered a heart attack or have died of an unexplainable cause?	O	O	O

********** ****For office use only**********

T: _____ P: _____ BP: _____/_____ R: _____ HT: _____ WT: _____
Vision: OD: _____ OS: _____ ___ Corrected OD: _____ OS: _____

	N/L	ABA/Comments		N/L	ABA/Comments
Appearance			Abdomen		
Head			Hernia		
Eyes (Pupils) ENT			Genitalia		
Teeth			Shoulder/Upper Extr.		
Thyroid			Scoliosis		
Nodes			Skin		
Chest			Spine		
Heart			Neurologic		
Lungs			Ankles/Lower Extr.		

HCT: _____ UA: _____ _____ OTHER: _____

IMP: _____

Plan: _____ Immun. Needed: _____ RX: _____

Recommendation: O No Athletic Participation O Limited Participation O Full Unlimited Participation

PHYSICIAN SIGNATURE _____ DATE _____