

ATEP Recommended Physical Evaluation Form

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers below. Circle the questions that you don't know the answers.

Yes No

Yes No

- | | | | | | | | | | | | | | | | | | | | |
|---|---|------------------------------------|--------------------------------|------------------------------|-------------------------------|----------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|------------------------------------|-----------------------------------|---------------------------------|--------------------------------|------------------------------------|-------------------------------|--|
| <p>1. Have you had a medical illness or injury since your last check up or physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Has a physician ever denied or restricted your participation in sports for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you ever had numbness or tingling in your arms, hands, legs, or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>22. Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Do you cough, wheeze, or have trouble breathing during or after activity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, check appropriate box and explain below.</p> <table border="0" style="margin-left: 40px;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Foot</td> <td></td> </tr> </table> <p>33. Do you want to weigh more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Record the dates of your most recent immunizations (shots) for:
 Tetanus _____
 Measles _____
 Chickenpox _____
 Hepatitis B vaccination schedule:
 1st _____
 2nd _____
 3rd _____</p> <p>36. Record the most recent date of your Tuberculosis test: _____ positive or negative? (Circle one)</p> | <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip | <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Foot | |
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Foot | | | | | | | | | | | | | | | | | | |

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature _____ Signature of parent/guardian _____ Date _____

ATEP Recommended Physical Evaluation Form

PHYSICAL EXAMINATION

Name _____	Date of birth _____
Height _____	Weight _____ % Body fat (optional) _____
Pulse _____	BP ____/____ (____/____, ____/____)
Vision R 20/____ L 20/____	Corrected: 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			
MUSCULOSKELTAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

Recommendations: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO