



**PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Classification \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

Follow-Up Questions on More Sensitive Issues	Yes	No
1. Have you ever tried cigarette smoking, even 1 or 2 puffs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
3. During the past 30 days, did you use chewing tobacco, snuff, or dip?	<input type="checkbox"/>	<input type="checkbox"/>
4. During the past 30 days, have you had at least 1 drink of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken steroid pills or shots without a doctor's prescription?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
Notes: _____		

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
Urine Analysis			

Notes: \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Notes: \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

