

ATHLETIC PHYSICAL EXAM FORM

NAME _____ Height: _____ Weight: _____

Age: _____ Blood Pressure: _____ Pulse: _____

| | Normal | Abnormal | Right/Left | Findings |
|--------------|--------------------------|--------------------------|---|----------|
| Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Ears | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Nose/Throat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Chest/Lungs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Heart | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Abdomen | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Wrists/Hands | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Hips/Legs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Knees/Legs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Back/Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | _____ |

May participate in UNRESTRICTED activity

May participate in RESTRICTED activity

Limitations _____

Signature _____ M.D. Date _____