



# TACOMA BAPTIST JR/SR HIGH SCHOOL PHYSICAL HISTORY & EXAMINATION FORM

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Exam Date \_\_\_\_\_  
Last First  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

## HISTORY

Yes No

1. \_\_\_\_\_ Have you had any illness/injury recently, or do you have an illness/injury now?
  - a. \_\_\_\_\_ Have you had a medical problem, illness or injury since your last exam?
  - b. \_\_\_\_\_ Do you have any chronic or recurrent illness?
  - c. \_\_\_\_\_ Have you ever had any illness lasting more than a week?
  - d. \_\_\_\_\_ Have you ever been hospitalized overnight?
  - e. \_\_\_\_\_ Have you had any surgery other than tonsillectomy?
  - f. \_\_\_\_\_ Have you ever had any injuries requiring treatment by a physician?
  - g. \_\_\_\_\_ Do you have any organ missing other than tonsils ( appendix, eye, kidney, testicle, etc.)?
2. \_\_\_\_\_ Are you presently taking ANY medications (including birth control pills, vitamins, aspirin, etc.)?
3. \_\_\_\_\_ Do you have ANY allergies (medicines, bees, foods, or other factors)?
4. \_\_\_\_\_ Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
  - a. \_\_\_\_\_ Do you tire more easily or quickly than your friends during exercise?
  - b. \_\_\_\_\_ Have you ever had any problem with your blood pressure or your heart?
  - c. \_\_\_\_\_ Have any close relatives had heart problems, heart attack or sudden death before they were age 50?
5. \_\_\_\_\_ Do you have any skin problems (acne, itching, rashes, etc.)?
6. \_\_\_\_\_ Have you ever had fainting, convulsions, seizures or severe dizziness?
  - a. \_\_\_\_\_ Do you have frequent severe headaches?
  - b. \_\_\_\_\_ Have you ever had a "stinger" or "burner" or "pinched nerve"?
  - c. \_\_\_\_\_ Have you ever been "knocked out" or "passed out"?
  - d. \_\_\_\_\_ Have you ever had a neck or head injury?
7. \_\_\_\_\_ Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
8. \_\_\_\_\_ Have you had asthma, or trouble breathing, or cough during or after exercise?
9. \_\_\_\_\_ Do you wear eyeglasses, contact lenses or protective eye wear?
  - a. \_\_\_\_\_ Have you had any problem with your eyes or vision?
10. \_\_\_\_\_ Do you wear any dental appliance such as braces, bridge, plate, retainer?
11. \_\_\_\_\_ Have you ever had a knee injury?
  - a. \_\_\_\_\_ Have you ever had an ankle injury?
  - b. \_\_\_\_\_ Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
  - c. \_\_\_\_\_ Have you ever had a broken bone (fracture)?
  - d. \_\_\_\_\_ Have you ever had a cast, splint, or had to use crutches?
  - e. \_\_\_\_\_ Must you use special equipment for competition (pads, braces, neck roll, etc.)?
12. \_\_\_\_\_ Has it been more than 5 years since your last tetanus booster shot?
13. \_\_\_\_\_ Are you worried about your weight?
14. \_\_\_\_\_ FEMALES: Have you any menstrual problems?
15. \_\_\_\_\_ Have you any medical concerns about participating in your sport?

\*\*\*\*\* ATHLETE SHOULD NOT WRITE BELOW THIS LINE \*\*\*\*\*

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):

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# TACOMA BAPTIST PHYSICAL EXAMINATION FORM

NAME: \_\_\_\_\_  
Last First

Age: \_\_\_\_\_ Pulse: \_\_\_\_\_

Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Weight: \_\_\_\_\_ Visual Acuity: Left 20/\_\_\_\_\_  
Right 20/\_\_\_\_\_

Urinalysis: \_\_\_\_\_ (Optional)

Body Fat % \_\_\_\_\_

HCT: \_\_\_\_\_

EST VO2 Max: \_\_\_\_\_

Audiometry: \_\_\_\_\_

Normal		Abnormal	
___	1. Head	___	_____
___	2. Eyes (pupils), ENT	___	_____
___	3. Teeth	___	_____
___	4. Chest	___	_____
___	5. Lungs	___	_____
___	6. Heart	___	_____
___	7. Abdomen	___	_____
___	8. Genitalia	___	_____
___	9. Neurologic	___	_____
___	10. Skin	___	_____
___	11. Physical Maturity	___	_____
___	12. Spine, Back	___	_____
___	13. Shoulders, Upper extremities	___	_____
___	14. Lower extremities	___	_____

Assessment:    \_\_\_ Full participation  
                   \_\_\_ Limited participation (describe limitations, restrictions):  
 \_\_\_\_\_  
 \_\_\_\_\_

      \_\_\_ Participation contraindicated (list reasons):  
 \_\_\_\_\_  
 \_\_\_\_\_

Recommendations (equipment, taping, rehabilitation, etc.):  
 \_\_\_\_\_  
 \_\_\_\_\_

EXAM DATE \_\_\_\_\_ EXAMINER'S SIGNATURE \_\_\_\_\_

EXAMINER'S PHONE \_\_\_\_\_ PRINT EXAMINER'S NAME \_\_\_\_\_