



PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- 1. Consider additional questions on more sensitive issues.
• Do you feel stressed out or under a lot of pressure?
• Do you ever feel sad, hopeless, depressed or anxious?
• Do you feel safe at your home or residence?
• Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?
• Have you ever taken anabolic steroids or used any other performance supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?
• Do you wear a seat belt, use a helmet or use condoms?
• Do you consume energy drinks?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

Table with columns for EXAMINATION, DATE OF EXAMINATION, and ABNORMAL FINDINGS. Rows include Height, Weight, BP, Pulse, Vision, L20, Corrected, MEDICAL (Appearance, Eyes/ears/nose/throat, Lymph nodes, Heart, Pulses, Lungs, Abdomen, Genitourinary, Skin, Neurologic), MUSCULOSKELETAL (Neck, Back, Shoulder/arm, Elbow/forearm, Wrist/hand/fingers, Hip/thigh, Knee, Leg/ankle, Foot/toes, Functional).

ªConsider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
ºConsider GU exam if in private setting. Having third part present is recommended.
ºConsider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

