

Physical Form  **MMC Physical Form**

Name _____ Age _____ Exam Date _____
 Social Security Number: _____ Birth Date: _____
 Home Address: _____ City _____ State _____ Zip _____
 Home Telephone Number: _____ Sport: _____

Medical History

YES NO

		Chronic or recurrent illnesses? (diabetes, asthma, ulcers, etc)
		Hospitalizations?
		Illness lasting more than a week?
		Surgery other than tonsillectomy? (tonsils removed)
		Surgery advised and not done?
		Presently taking any medications? (if so list)
		Problem with blood pressure or heart?
		Seizures, dizziness, fainting, convulsions or frequent headaches?
		Ever been knocked out or had a concussion?
		Wear eyeglasses or contact lenses?
		Wear any dental appliance such as: braces, bridge, or plates?
		Allergic to ANY medication (aspirin, penicillin, etc.)? (if so list)
		Allergic to ANY foods (shrimp, poppy seeds, tomatoes, etc.)? (if so list)
		Organ missing other than tonsils (appendix, eye, kidney, testicle)?
		Heat exhaustion or heat stroke?
		History of enlarged liver or spleen?
		History of collapsed lung or tuberculosis?
		Serious eye injuries?
		Has any family member died suddenly at less than age of 40 of illness (not an accident)?
		Has any family member had a heart attack before age 55?
		History of knee injury?
		History of ankle injury?
		History of neck injury?
		History of other joint sprains or dislocations (shoulder, wrist, finger, etc)?
		History of broken bones (fractures)?
		Date of last known tetanus (lockjaw) shot.

Weight _____ Pulse Rate _____ b/min Height _____ Blood Pressure _____
 Vision R _____ L _____ Both _____ Corrective Lense ___ Y/ ___ N

Musculo-Skeletal Assessment

Grade of 1,2,3

1 = poor, 2 = average, 3 = good

	R	L	Comments		R	L	Comments
Single Leg Squat				Shoulder ROM			
Hamstrings				Shoulder Flex.			
Heel Cord				Scoliosis			
Hip Flexibility				Lordosis/kyphosis			
Knee ROM				Neck ROM			

General Physical Examination

	Normal	Abnormal	Not Examined	Comments	Dr. Initials
Eyes					
Ear, Nose, Throat					
Chest, Lungs					
Abdomen					
Skin/Lymphatics					

Physicians Signature _____ Date _____

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