TKA SPORTS PHYSICAL EVALUATION HISTORY DATE: Phone: (____)_ Name: _____ St: ____ ZIP: ___ _City: _ ____ Age: ______ Date of Birth: ______ Grade: _____ Phone: (____) Personal Physician: ___ Previous school attended and dates: Explain "YES" answers below: YES NO 1. Have you ever been hospitalized? Have you ever had surgery? _____ Are you presently under a doctor's care? 2. Are you presently taking any medications or pills? 3. Do you have any allergies (medicine, bees or other stinging insects)? 4. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Have you ever had high blood pressure? _____ Have you ever been told that you have a heart murmur? Have you ever had racing of your heart or skipped heartbeats? 5. Do you have any skin problems (itching, rashes, acne)? _____ Have you ever been knocked out or unconscious? Have you ever had a seizure, "fit" or epilepsy? 7. Have you ever had heat cramps, heat illness or muscle cramps? 8. Do you have trouble breathing or do you cough during or after activity? 9. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)? 10. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear? 11. Are you missing an eye, kidney or testicle? 12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ____Elbow Foot Head Shoulder __Thigh Neck Knee Shin/Calf Wrist _Ankle Forearm Back _Hip Hand 13. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)? 14. Have you had a medical problem or injury since your last evaluation? 15. When was your last tetanus shot?

Explain "YES" answers:	
I hereby state that, to the best of my knowledge, my answers to the abo	ove questions are correct.
Date:	
Signature of athlete:	Signature of Parent/Guardian

PHYSICAL EXAMINA	TION			DATE:	
Name:				Age:	Date of Birth:
Height:	V	Veight:		BP:	Pulse:
Vision: R 20/	L 2	0/	Corrected:	Y N	Pupils (circle) Equal/Unequal R>L L>R
	Circle (if	option given)			Specific Findings
Heart	Circle (ii	option given)			Specific Findings
Rhythm	Regular	Irregular			
Murmur (supine)	NO	YES			
Murmur (standing)	NO	YES			
	No	rmal (X)			
Lungs					
Skin					
Abdominal					
Femoral Pulses					
Genitalia/Hernia					
Musculoskeletal:					
Neck					
Shoulders					
Elbows					
Wrists					
Hands					
Back					
Knees					
Ankles					
Feet					
Other					
Clearance: A. Cleared B. Cleared after complete. C. Not cleared Due to:					
	s athlete ph Basketball Ill, Cross Co	ysically unfit to , Cross Country ountry, Soccer,	engage in any s , Soccer, Tennis Softball, Tennis	sport, exc o s, Track, V , Track, V	/olleyball
Phone ()					
Signature of Physician	:				

(Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy of Sports Medicine.)