LONG VALLEY HEALTH CENTER
SPORTS PHYSICAL FORM

Name____ Date____________

What sports are you going to play this year?

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PATIENT HISTORY

YES	NO	UNCERTAIN	
❑	❑	❑	Have you ever had a hit or blow to the head that caused confusion, prolonged headache, memory problems or loss of consciousness?
❑	❑	❑	Chest pain or discomfort when you exert yourself
❑	❑	❑	Fainting or near fainting
❑	❑	❑	Asthma, coughing, wheezing or difficulty breathing after exercise
❑	❑	❑	Heart murmur
❑	❑	❑	Broken bone, dislocation or sprain
❑	❑	❑	Heat-related illness
❑	❑	❑	Chronic Medical Condition (e.g. asthma, seizure disorder) (List:__________________________________)
❑	❑	❑	Absence of a paired organ (Circle - eyes, ears, kidneys, testicles, ovaries)
❑	❑	❑	Any chronic medications (List:__________________________________)
❑	❑	❑	Allergy to medicine or bee stings (List:__________________________________)
❑	❑	❑	Family history of “Sudden Death” or heart disease before age 50
❑	❑	❑	Immunizations up-to-date
❑	❑	❑	Swimmers: recurrent external ear infection
❑	❑	❑	Wrestlers: cold sores, athlete’s foot, skin fungus, MRSA
❑	❑	❑	Adolescent lifestyle issues or concerns (sex, tobacco, alcohol, steroids, other drugs)