

SUNY Potsdam Sports Medicine

PHYSICAL EXAMINATION FORM

Name _____ Sport _____ Date of birth _____

PHYSICIAN REMINDERS

Consider additional questions or more sensitive issues:

- Do you ever feel sad, hopeless, depressed, or anxious?
- Do you feel safe at your home or residence?
- Are you currently using tobacco products?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or have used any performance supplements?
- Have you ever taken any supplements to help you gain or lose weight?



EXAMINATION		
Height:	Weight:	Male <input type="checkbox"/> Female <input type="checkbox"/>
BP / (/)	Pulse	Vision R20/ L20/ Corrected: Y <input type="checkbox"/> N <input type="checkbox"/>
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (Kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Cardiovascular		
Respiratory		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional/ROM		

-Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
-Consider GU exam if in private setting. Having third party present is recommended.
-Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- No contraindication to Full Athletic Participation
 No contraindication to Full Athletic Participation but further evaluation and treatment recommended

for: _____

- This student should not participate in athletics:

Reason: _____

I have examined the above-named student and completed the pre-participation physical evaluation. The recommendations I have made above indicate my professional assessment regarding this athlete's ability to safely participate in the sport(s) indicated. A copy of the physical exam is on record in my office and can be made available to the school at the request of the athlete (or parent/guardian if the athlete is a minor). I understand that conditions may arise that may change my recommendations. I understand I may alter my recommendations until the conditions are safely resolved and the potential consequences are completely explained to the athlete (or parents/guardians if the athlete is a minor).

Name of physician (Print/Type) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____, MD or DO