[ ]Ht/Wt [ ]BP [ ]Hx [ ]ROM

Uptown Wellness Center

Pre-Participation / Employment Physical Exam Form

First & Last Name: _____ Gender: M / F Current Age: _____ Grade #____
Date of Birth: _____ Tel#:( )_____ Email:_____
School / Organization / Company Name _____ Sports/Activity: _____

1. Recent Injury / Trauma / Surgery / Hospital Visits (Date/Condition) [ ]None [ ]Bone Fracture [ ]Infection
[ ]Other Injuries:_____
2. Current Medications / Prescribed & Non-Prescribed (Name/Condition): [ ]None [ ]Inhaler/Nebulizer [ ]Blood Pressure
[ ]Other Medications:_____
3. Allergies: [ ]None [ ]Medicines [ ]Pollens [ ]Food [ ]Stinging insects **4.Teeth**: [ ]Braces [ ]Retainers [ ]Chipped [ ]Missing
5. Vision/Hearing Aids: [ ]None [ ]Glasses [ ]Contacts [ ]Sports goggles [ ]Face shield [ ]Hearing aids [ ]Ear tubes
6. Family Health History: [ ]None [ ]Pacemaker [ ]Defibrillator [ ]Cardiomyopathy [ ]Tachycardia [ ]Asthma [ ]Sickle Cell Disease
[ ]Other Family Health Issues:_____
7. Previous Sports/Work Activity Restrictions/Denials: [ ]None [ ]Other:_____

8. Does the participant NOW have OR EVER had HEALTH ISSUES during EXERCISE?

[ ]NONE [ ]Asthma [ ]Passing out or nearly passing out [ ]Chest discomfort, pain, tightness, pressure [ ]Shortness of breath
[ ]Severe fatigue/tiredness [ ]Heart races, skip beats, irregular beats [ ]Lightheaded [ ]Severe fatigue/tiredness [ ]Seizures
[ ]Cough, wheeze, difficult breathing [ ]Prolonged headaches [ ]Heat stroke/exhaustion [ ]Muscle cramps [ ]Vomiting

9. Does the participant NOW have OR EVER had HEALTH ISSUES with any of the following ORGANS?

[ ]NONE [ ]Brain [ ]Eyes [ ]Thyroid [ ]Heart [ ]Liver [ ]Kidney [ ]Stomach [ ]Pancreas [ ]Gall bladder [ ]Spleen [ ]Lungs [ ]Intestines
[ ]Prostate [ ]Uterus [ ]Ovaries [ ]Testicles [ ]Adrenal glands [ ]OTHER:

Does the participant NOW have OR EVER had any of the following HEALTH ISSUES:

		YES*	NO			YES*	NO
10	Concussion / Loss of Consciousness			25	Diabetes		
11	Memory problems, Confusion			26	Hernia / Groin pain		
12	Seizures, Convulsions, Dizziness, Fainting			27	Absence of any organ		
13	After hit/fall: Weakness, numb, tingling in arms/legs			28	Absence / Undescended testicle		
14	Nose, Throat, Breathing problems			29	Eye injuries/surgeries		
15	High blood pressure			30	Arthritis / Connective tissue		
16	Heart murmur / infection			31	Skin infection / Eczema / Rashes		
17	Anemia / Bleeding diseases			32	ADD / ADHD / Downs / Palsy		
18	Lymph node / Lymphatic problems			33	Mono (Infectious Mononucleosis)		
19	Kawasaki disease			34	Ear infections, ruptured ear drum		
20	High cholesterol			35	Cancer		
21	Heart tests: EKG/ECG/Echocardiogram			36	Crutches/Cane/Cast/Brace		
22	X-Rays/CT scan/MRI			37	Dwarfism / Growth / Metabolic		
23	Mental health problems / Learning disabilities			38	Syndromes: Marfan/QT/ Brugada		
24	Recent Weight Gain/Loss, Eating disorders			39	Severe menstrual problems		

40.Does participant NOW have OR EVER had any BROKEN BONES / INJURIES / DISLOCATIONS to any of the following?

	YES*	NO		YES*	NO		YES*	NO
Head			Wrist Right / Left			Thigh Right / Left		
Neck			Hand Right / Left			Calf Right / Left		
Spine			Fingers Right / Left			Ankle Right / Left		
Shoulder Right / Left			Hip Right / Left			Foot Right / Left		
Elbow Right / Left			Knee Right / Left			Toes Right / Left		

OTHER:

DO YOU HAVE ANY OTHER CONCERNS TO DISCUSS WITH THE DOCTOR: [ ]YES* [ ]NO

***EXPLAIN ALL YES ANSWERS HERE: (Date, details, treatment, complications, etc)**

([ ]Continued on back of this paper)

I hereby state that the answers to the above questions are complete and accurate. I understand that this exam is for screening purposes only & is not medically diagnostic. If Minor Participant: I consent for above participant to receive a pre-participation physical examination.

► _____ X_____ _____

PRINT: Legal Age Participant/Parent/Guardian **SIGN**: Legal Age Participant/Parent/Guardian **DATE**