

Physical Evaluation

Name: _____ Sex: _____ Age: _____ Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Personal/Family Physician: _____ City/State: _____ Phone: _____

Medical History (Explain "yes" answers below. Circle questions you do not know the answer to.)

- | | | | | | |
|--|-----|----|--|-----|----|
| 1. Have you had a medical illness or injury in the last 5 years? | Yes | No | 17. Have you ever had a head injury or concussion? | Yes | No |
| 2. Do you have problems with your eyes, ears, nose or throat? | Yes | No | 18. Have you ever had a seizure? | Yes | No |
| 3. Do you wear corrective lenses? | Yes | No | 19. Do you have frequent or severe headaches? | Yes | No |
| 4. Do you have an ongoing chronic illness? | Yes | No | 20. Have you ever been knocked out, become unconscious or lost your memory? | Yes | No |
| 5. Have you ever been hospitalized overnight? | Yes | No | 21. Have you had any problems with your eyes or vision? | Yes | No |
| 6. Have you ever had surgery? | Yes | No | 22. Do you wear glasses, contacts or protective eyewear? | Yes | No |
| 7. Are you currently taking any prescription or non-prescription (over-the counter) medications? | Yes | No | 23. Have you ever had a sprain, strain or swelling after injury? | Yes | No |
| 8. Do you have any allergies (i.e. pollen, medicine, food, animals, or stinging insects)? | Yes | No | 24. Have you broken or fractured any bones or dislocated any joints? | Yes | No |
| 9. Do you have seasonal allergies that require medical treatment? | Yes | No | 25. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | Yes | No |
| 10. Do you have asthma? | Yes | No | 26. Have you ever had sleep disorders (i.e. pauses in breathing while asleep, daytime sleepiness, loud snoring)? | Yes | No |
| 11. Do you cough, wheeze or have trouble breathing during or after activity? | Yes | No | 27. Have you ever had diabetes or elevated blood sugar? | Yes | No |
| 12. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus or blisters)? | Yes | No | 28. Have you ever had numbness or tingling in your arms, hands, legs or feet? | Yes | No |
| 13. Have you ever had racing of your heart or skipped heartbeats? | Yes | No | 29. Do you frequently consume alcohol? | Yes | No |
| 14. Have you had high blood pressure or high cholesterol? | Yes | No | 30. Do you use narcotic or habit forming drugs? | Yes | No |
| 15. Have you ever been told you have a heart murmur? | Yes | No | | | |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | Yes | No | | | |

Explain "Yes" answers here:

Health Care Worker Physical Exam Form

Marcel A. Müller



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