FAMILY CHOICE MEDICAL CLINIC, P.A.

Sports Physical Form

Name: ______________________________ Gender: M F Date of Birth: ___/___/___
Father's Name: ____________________ Daytime phone, pager, cell phone: ____________________
Mother's Name: ____________________ Daytime, phone, pager, cell phone: ____________________
Street address: ____
City: ______________ State: ______ Zip Code: ________ Home phone: ____________________
Alternate Emergency Contact Person: ____________________ Daytime phone: ____________________
Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.: ____________________
____

Medical History:

Athletes and parents: This health record is a critical element in the determination of an athlete's risk of injury in sports. Please take the time to read and answer all questions before seeing a physician for the athlete's physical examination.

1. Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50? YES NO Don't Know
2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? YES NO Don't Know
3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? YES NO Don't Know
4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? YES NO Don't Know
5. Does the athlete have a history of concussion (getting knocked out)? YES NO Don't Know
6. Has the athlete ever suffered a heat-related illness (heat stroke)? YES NO Don't Know
7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? YES NO Don't Know
8. Does the athlete take any medication(s)? YES NO Don't Know
9. Is the athlete allergic to any medications or bee stings? YES NO Don't Know
10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries) YES NO Don't Know
11. Has the athlete had an injury in the last year that caused the athlete to miss 3 or more YES NO Don't Know
    consecutive days of practice or competition? YES NO Don't Know
12. Has the athlete had surgery or been hospitalized in the past year? YES NO Don't Know
13. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? YES NO Don't Know
14. Are you, the athlete, worried about any problem or condition at this time? YES NO Don't Know

Please give details on any "YES" answer from the above health history.

____
____
____
____
____

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height __________ Weight __________ Pulse __________ Blood Pressure __________

Vision: R _____ / _____ uncorrected R _____ / _____ corrected L _____ / _____ uncorrected L _____ / _____ corrected

	Normal	Abnormal Findings	Initials
1. Eyes			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck			
5. Cardiovascular			
6. Chest & Lungs			
7. Abdomen			
8. Skin			
9. Genitalia-Hernia (male)			
10. Muskuloskeletal: ROM, strength, etc.			
a. neck			
b. spine			
c. shoulders			
d. arms/ hands			
e. hips			
f. thighs			
g. knees			
h. ankles			
i. feet			
11. Neuromuscular			

Please Print/ Stamp

Physician's Name ____
Street Address ____
City, State, Zip Code ____
Telephone ____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature ____________________________________ Date ______________

PARTICIPATION RESTRICTIONS: ____
____
____

FAMILY CHOICE MEDICAL CLINIC, P.A.

PRE-OP EVALUATION FORM

NAME: ______________________ DATE: ______________________

DOB: ______________________ AGE: ______________ SEX: M/F

HISTORY OF PRESENT ILLNESS: ____

____

____

ALLERGIES/REACTIONS: ____

____

CURRENT MEDICATIONS: ____

____

PAST MEDICAL/SURGICAL HISTORY: ____

____

PHYSICAL EXAMINATION			
	HEIGHT:__________	WEIGHT: ________	TEMP.: ________
VITAL SIGNS:	B/P__________	PULSE: ________	RESP.: ________
MENTAL STATUS:			
HEENT:			
CHEST:			
HEART:			
ABDOMEN:			
EXTREMITIES:			
OTHER PERTINENT INFORMATION:			

DIAGNOSIS: ____

PROPOSED SURGERY/PROCEDURE: ____

CLEARED FOR SURGERY: ( ) YES ( ) NO

PHYSICIAN SIGNATURE: ______________________________ DATE: ______________

FAMILYCHOICE MEDICAL CLINIC
GYNECOLOGIC EXAM

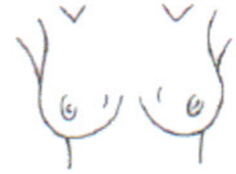
Patient Name: ______________________ DOB: __________ Date: __________ Time: __________ a/p Chart #: __________

Ht: __________ Wt: __________ T: __________ P: __________ R: __________ BP: __________ LNMP: __________

Arrived: ☐ Ambulatory ☐ Assisted ☐ with Parent or Guardian		Allergies:
Learning Barriers: ☐ Y ☐ N ☐ Language ☐ Culture Other:		
Immun UTD: ☐ Y ☐ N	Advanced Directive: ☐ Y ☐ N	
Smoker: ☐ Y ☐ N	Alcohol: ☐ Y ☐ N	Drug Abuse: ☐ Y ☐ N
Pain Assessment Scale: 1 – 10	Area of Pain:	

Age: __________ M / F Chief Complaint: ______________________ Sign: __________

☐ SMHW



PHYSICAL EXAM (Circle or √ affirmative, slash negatives)	**ABNORMAL FINDINGS:**
GENERAL: ☐ NAD ☐ vital signs noted ☐ alert	
EENT: ☐ PERRL ☐ conjunctiva, sclera, lids nl ☐ EOMI ☐ fund. exam ☐ nose patent ☐ rhinorrhea ☐ canals clear ☐ TMs nl bilateral ☐ mucosa, tongue, palate, tonsils, pharynx nl	
NECK: ☐ bruits ☐ lymphadenopathy ☐ goiter ☐ nuchal rigidity	
LUNGS: ☐ nl resp. effort ☐ rales, rhonchi, wheezes ☐ CTAB	
CV: ☐ regular rhythm nl S1, S2 ☐ murmur ☐ nl pulses ☐ edema	
BREAST: ☐ masses ☐ nipple DC ☐ nipple dimpling ☐ axillary adenopathy ☐ lumps ☐ symmetry ☐ tenderness ☐ examined sitting ☐ examined supine	
ABD / GI: ☐ BS nl ☐ soft ☐ tender ☐ distension ☐ masses ☐ o-megaly ☐ rectal normal ☐ Hemoccult neg. ☐ RBT ☐ CVAT	
GU: Female: External Genitalia: ☐ appearance/hair distributions nl ☐ lesions Urethral/Meatus: ☐ size/location nl ☐ prolapse ☐ tenderness Vagina: ☐ appearance nl ☐ atrophic ☐ discharge ☐ lesions ☐ Cyctocele ☐ Rectocele Cervix: ☐ absent ☐ nulliparous ☐ parous ☐ lesions ☐ discharge Uterus: ☐ absent ☐ normal size ☐ enlarged ☐ fibroids palpable ☐ midline ☐ anteflexed ☐ retroflexed ☐ military position Adenexa: ☐ masses ☐ nodularity ☐ tenderness Rectal: ☐ hemorrhoids ☐ masses ☐ tone nl Hemoccult: ☐ Negative ☐ Positive ☐not done ☐ declined ☐ not enough stool KOH/Wet Prep: ☐ negative ☐ positive	
PSYCH: ☐ nl speech ☐ appropriate affect ☐ thoughts logical/relevant ☐ memory intact	

ASSESSMENT:

1. ☐ Healthy Well Woman Exam
2. ☐ Family Planning
3.
4.
5.

PLAN:

1. ☐ Pap smear and CBE Completed
2. ☐ BSE reviewed with patient
3. ☐ Mammogram, Screening/Diagnostic referred
4. ☐ G/C check
5. F/U ______________
6. ☐ Labs Ordered (not under SMHW)

If Smoker, cessation addressed? ______________ Referral: ______________ ☐ Accept ☐ Decline

Discussed with: ☐ Patient ☐ Family Member ☐ Other	Agrees to treatment: ☐ Yes ☐ No	Patient Verbalized Understanding? ☐ Yes ☐ No
Left: ☐ Ambulatory ☐ Assisted ☐ Wheel Chair ☐ Ambulance		Educational Materials: ☐ Yes ☐ No