



To be Completed by a Medical Doctor

A medical questionnaire completed by the athlete should accompany her/him to this physician visit.

Athlete's Name: _____ Birthdate: _____

Height: _____ Weight _____ BP _____ / _____

Resting Pulse: _____

Visual acuity (uncorrected) R _____ / _____ L _____ / _____

(corrected): R _____ / _____ L _____ / _____

Color Blindness: _____ EENT, thyroid: _____

Teeth: _____

Chest: _____

Cardiovascular: _____

Abdomen (including hernias, testicles): _____

CNS: _____ DTR's: _____ Skin: _____

Musculoskeletal (*please note any evidence of prior injury, instability, or loss of flexibility*)

Hand/Wrist: _____

Elbow: _____

Shoulder: _____

Neck/Back: _____

Scoliosis: _____

Hip/Pelvis: _____

Knee: _____

Ankle/Feet: _____

Additional Comments/Abnormal Findings (also use reverse): _____

Laboratory (If indicated) CBC _____ Urine _____

Others (as indicated): _____

X-rays (as indicated):-

Recommendations re: Participation:

Notes:

No restrictions (Contact/Collision) _____
Limited Contact/Impact _____
Non-Contact _____
 Strenuous _____
 Moderate _____
 Non-strenuous _____
Needs further consultation/tests _____
Not fit _____

Recommendations prior to participation (eg. Rehabilitation): _____

Please add any relevant information from this page to the Problem List/Current Treatments on the athlete medical questionnaire that should accompany the athlete during her physician visit.

Examining Physician (Print): _____

Physician Signature: _____

Address: _____ **City:** _____

Prov: _____ **Postal Code:** _____

Date of Examination: _____ **Phone:(**) _____