## 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):________________________________________

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:**(    )___________________