



# PHYSICIAN'S HEALTH EVALUATION

**To the Examining Physician:** Please review the student's history and complete the physician's form. Please comment on all positive answers. This student has been accepted for Admission. The information supplied will not affect the student's status: it will be used only as a background for providing health care as necessary. This information is strictly for the use of the Health Services Office and will not be released without student consent.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Gender (circle) M / F

BP \_\_\_\_\_ Height ft. \_\_\_\_ in \_\_\_\_ Weight \_\_\_\_\_ lbs. Overweight \_\_\_\_\_ Underweight \_\_\_\_\_

Corrected Vision: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Tuberculin Skin Test: Pos. \_\_\_\_ Neg. \_\_\_\_

**URINALYSIS**

|         |  |
|---------|--|
| Sugar   |  |
| Albumin |  |
| Micro.  |  |

HEMOGLOBIN (if indicated)  
\_\_\_\_\_ gms/%

**Are there abnormalities of the following systems? Describe fully. Use additional paper if needed.**

|                          | Yes | No |
|--------------------------|-----|----|
| Head, Ears, Nose, Throat |     |    |
| Respiratory              |     |    |
| Cardiovascular           |     |    |
| Gastrointestinal         |     |    |
| Hernia                   |     |    |
| Eyes                     |     |    |
| Genitourinary            |     |    |
| Musculoskeletal          |     |    |
| Metabolic/Endocrine      |     |    |
| Neuropsychiatric         |     |    |
| Skin                     |     |    |

**IMMUNIZATIONS**

| Immunization                                 | Completed |    | Date |
|--|-----------|----|------|
|  | Yes       | No |      |
| Tetanus Toxoid (booster)                     |           |    |      |
| D.P.T. (3 basic and 3 boosters)              |           |    |      |
| M.M.R. (2 Doses (Measles, Mumps and Rubella) |           |    |      |
| Polio (3 doses - live or Salk)               |           |    |      |
| Hepatitis                                    |           |    |      |
| Meningococcal Conjugate (groups A/C/Y/W-135) |           |    |      |

Is there loss or seriously impaired function of any paired organ?     Yes     No

General Comments:

  
  
  

Recommendations for physical activity (PE, Intramurals, ROTC): Unlimited \_\_\_\_\_ Limited \_\_\_\_\_  
Explain:

Do you have any recommendations regarding the care of this student?    Yes \_\_\_\_\_    No \_\_\_\_\_

Is the patient now under treatment for any medical or emotional condition?    Yes \_\_\_\_\_    No \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Print Last Name \_\_\_\_\_ Date \_\_\_\_\_

*This recommended form has been approved by the Liaison Committee for the American College Health Association and the American Medical Association and approved by the American College Health Association.*

# SPORTS MEDICINE ORTHOPEDIC EVALUATION ( VARSITY ATHLETES ONLY )

This physical examination form is only to be completed if the student is going to participate in intercollegiate athletics at Geneva College.

**To the Examining Physician:** Please review the student's history and complete this sports medicine orthopedic form. This student has been accepted for Admission. The information supplied will not affect the student's status as a student, but is used to declare the student-athlete fit for collegiate athletic competition. It will be used only as a background for providing health care as necessary. This information is strictly for the use of the Athletic Training Services and will not be released without the student's consent.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Varsity Sport \_\_\_\_\_ Gender (circle) M / F

| Body Part | Symptoms   | Normal | Abnormal |
|-----------|--|--------|----------|
| Thorax    | Shape, Expansion, Deformities                          |        |          |
| Lungs     | Bronchi, Wheezes, Rales                                |        |          |
| Heart     | Murmurs, etc.  |        |          |
| Nose      | Septum, Mucosa, Polyps, Sinuses                        |        |          |
| Ears      | Gross hearing to speech, Drums, Discharge              |        |          |
| Throat    | Tonsils, Lesions, Injections                           |        |          |
| Abdomen   | Organ Enlargement, Masses, Tenderness, Hernia or Scars |        |          |

BLOOD PRESSURE: \_\_\_\_\_

PULSE: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

HEIGHT: \_\_\_\_\_

| AREA     | NORMAL | ABNORMAL | COMMENTS |
|----------|--------|----------|----------|
| NECK     |        |          |          |
| SPINE    |        |          |          |
| SHOULDER |        |          |          |
| ELBOW    |        |          |          |
| WRIST    |        |          |          |
| HAND     |        |          |          |
| HIP      |        |          |          |
| ANKLE    |        |          |          |

**FEET:** (A) PES CAVUS (B) NORMAL (C) SPLAY (D) PES PLANUS (E) FLAT

COMMENTS: \_\_\_\_\_

| PATELLA               | YES | NO | COMMENTS |
|-----------------------|-----|----|----------|
| (A) PAIN              |     |    |          |
| (B) APPREHENSION TEST |     |    |          |
| (C) CREPITATION       |     |    |          |

**THIGH:**  
(A) TONE: \_\_\_\_\_  
(B) ATROPHY: \_\_\_\_\_

**KNEE: Please circle the appropriate response**

|                     | RIGHT |    |    | LEFT |     |    |    |    |
|---------------------|-------|----|----|------|-----|----|----|----|
| <b>LCL</b>          |       |    |    |      |     |    |    |    |
| EXTENSION           | NEG   | 1+ | 2+ | 3+   | NEG | 1+ | 2+ | 3+ |
| 30 DEGREES FLEXION  | NEG   | 1+ | 2+ | 3+   | NEG | 1+ | 2+ | 3+ |
| <b>MCL</b>          |       |    |    |      |     |    |    |    |
| EXTENSION           | NEG   | 1+ | 2+ | 3+   | NEG | 1+ | 2+ | 3+ |
| 30 DEGREES FLEXION  | NEG   | 1+ | 2+ | 3+   | NEG | 1+ | 2+ | 3+ |
| <b>ACL/PCL</b>      |       |    |    |      |     |    |    |    |
| LACHMANS            | NEG   | 1+ | 2+ | 3+   | NEG | 1+ | 2+ | 3+ |
| ENDPOINT            |       | A  | B  |      |     | A  | B  |    |
| ANTERIOR DRAWER     | NEG   | 1+ | 2+ | 3+   | NEG | 1+ | 2+ | 3+ |
| POSTERIOR DRAWER    | NEG   | 1+ | 2+ | 3+   | NEG | 1+ | 2+ | 3+ |
| PIVOT SHIFT         | NEG   | 1+ | 2+ | 3+   | NEG | 1+ | 2+ | 3+ |
| REVERSE PIVOT SHIFT | NEG   | 1+ | 2+ | 3+   | NEG | 1+ | 2+ | 3+ |

**PALPATION**  
 SCAR YES NO \_\_\_\_\_  
 PAIN YES NO \_\_\_\_\_  
 EFFUSION YES NO \_\_\_\_\_  
 SOFT TISSUE SWELLING YES NO \_\_\_\_\_

**PHYSICIAN'S SUMMARY**  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ NORMAL EXAMINATION-CLEARED FOR INTERCOLLEGIATE ATHLETICS

PHYSICIAN'S PRINTED NAME \_\_\_\_\_ PHYSICIAN'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_