AVORS MEDICAL GROUP

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Work Physical
Patient Forms Packet

- ☑ Patient Information
- ☑ Pre-Participation Evaluation Medical History
- ☑ Work Physical Evaluation Results (to be completed by Dr. Smith)

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Patient Information

Date of Exam _____

Name _____ Sex ❑ M ❑ F Date of Birth _____

Personal Physician _____

In case of emergency, contact:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Pre-Participation Evaluation
Medical History

Circle "Question Numbers" you do not know the answer to. Please explain "Yes" answers in blank lines at end of evaluation.

1.	Has a doctor ever denied or restricted your participation in sports for any reason?	❑ No ❑ Yes
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	❑ No ❑ Yes
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills?	❑ No ❑ Yes
4.	Do you have any allergies to medicine, pollens, foods, or stinging insects?	❑ No ❑ Yes
5.	Have you ever passed out or nearly passed out DURING exercise?	❑ No ❑ Yes
6.	Have you ever passed out or nearly passed out AFTER exercise?	❑ No ❑ Yes
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	❑ No ❑ Yes
8.	Does your heart race or skip beats during exercise?	❑ No ❑ Yes
9.	Has your doctor ever told you that you have (check all that apply)? ❑ High Blood Pressure ❑ Heart Murmur ❑ High Cholesterol ❑ Heart Infection	❑ No ❑ Yes
10.	Has a doctor ever ordered a test for your heart? (example: ECG or Echocardiogram)	❑ No ❑ Yes
11.	Has anyone in your family died for no apparent reason?	❑ No ❑ Yes
12.	Does anyone in your family have a heart problem?	❑ No ❑ Yes
13.	Has anyone in your family died of heart problems or of a sudden death before the age of 50?	❑ No ❑ Yes
14.	Does anyone in your family have Marfan syndrome?	❑ No ❑ Yes
15.	Have you ever spent the night in the hospital?	❑ No ❑ Yes
16.	Have you ever had surgery?	❑ No ❑ Yes

Pre-Participation Evaluation
Medical History (continued)

17.	Have you ever had an injury, like a sprain, muscle tear, or tendinitis that caused you to miss a practice or a game? If yes, check below? ❑ Head ❑ Neck ❑ Shoulder ❑ Upper Arm ❑ Elbow ❑ Forearm ❑ Hand/Fingers ❑ Hip ❑ Thigh ❑ Knee ❑ Calf/Shin ❑ Ankle ❑ Foot/Toe	❑ No ❑ Yes
18.	Have you ever had a broken or fractured bone or joint that required a brace, a cast or crutches? If yes, check below? ❑ Head ❑ Neck ❑ Shoulder ❑ Upper Arm ❑ Elbow ❑ Forearm ❑ Hand/Fingers ❑ Hip ❑ Thigh ❑ Knee ❑ Calf/Shin ❑ Ankle ❑ Foot/Toe	❑ No ❑ Yes
19.	Have you ever had a bone or joint injury that required X-Ray, MRI, CT, Surgery, Injections, Rehabilitation, Physical Therapy, a brace, a case, or crutches? If yes, check below? ❑ Head ❑ Neck ❑ Shoulder ❑ Upper Arm ❑ Elbow ❑ Forearm ❑ Hand/Fingers ❑ Hip ❑ Thigh ❑ Knee ❑ Calf/Shin ❑ Ankle ❑ Foot/Toe	❑ No ❑ Yes
20.	Have you ever had a stress fracture?	❑ No ❑ Yes
21.	Have you been told that you have or have had an x-ray for an atlantoaxial (neck) instability?	❑ No ❑ Yes
22.	Do you regularly use a brace or assistive device?	❑ No ❑ Yes
23.	Has a doctor ever told you that you have asthma or allergies?	❑ No ❑ Yes
24.	Do you have a cough, wheeze, or have difficulty breathing during or after exercise?	❑ No ❑ Yes
25.	Is there anyone in your family who has asthma?	❑ No ❑ Yes
26.	Have you ever used an inhaler or taken asthma medication?	❑ No ❑ Yes
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	❑ No ❑ Yes
28.	Have you had an infectious mononucleosis (mono) within the last month?	❑ No ❑ Yes
29.	Do you have any rashes, pressure sores, or other skin problems?	❑ No ❑ Yes
30.	Have you had herpes skin infections?	❑ No ❑ Yes
31.	Have you ever had a head injury or concussion?	❑ No ❑ Yes
32.	Have you ever been hit in the head and been confused or lost your memory?	❑ No ❑ Yes
33.	Have you ever had a seizure?	❑ No ❑ Yes
34.	Do you have headaches with exercise?	❑ No ❑ Yes
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	❑ No ❑ Yes
36.	Have you ever been unable to move your arms or legs after being hit or falling?	❑ No ❑ Yes
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	❑ No ❑ Yes
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	❑ No ❑ Yes

Pre-Participation Evaluation
Medical History (continued)

39.	Have you had any problems with your eyes or vision?	❑ No ❑ Yes
40.	Do you wear glasses or contact lenses?	❑ No ❑ Yes
41.	Do you wear protective eyewear, such as goggles or a face ligament shield?	❑ No ❑ Yes
42.	Are you happy with your weight?	❑ No ❑ Yes
43.	Are you trying to gain or lose weight?	❑ No ❑ Yes
44.	Has anyone recommended you change your weight?	❑ No ❑ Yes
45.	Do you limit or carefully control what you eat?	❑ No ❑ Yes
46.	Do you have any concerns that you would like to discuss with the doctor?	❑ No ❑ Yes
	Females Only	
47.	Have you ever had a menstrual cycle?	❑ No ❑ Yes
48.	How old were you when you had your first menstrual cycle? _____	
49.	How many periods have you had in the last 12 months? _____	

Explain “Yes” answers here:

_____

_____

_____

_____

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete _____

Signature of Parent/Guardian _____

Date _____

Work Physical
Evaluation Results
(to be completed by Dr. Smith)

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP _____/_____ (_____/_____, _____/_____)

Vision R 20/_____ L 20/_____ Corrected ❑ No ❑ Yes Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Work Physical
Evaluation Results (continued)
(to be completed by Dr. Smith)

❑ Cleared without restriction.

❑ Cleared with recommendations for further evaluation or treatment for _____

_____

❑ Not cleared for: ❑ All Sports ❑ Certain Sports_____

Reason _____

_____

_____

_____

Recommendations _____

_____

_____

_____

_____
Tony Smith, D.C.

_____
Date

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