NAME: ______________________________

RSD ACTIVITY CODE OF CONDUCT
Cedarcrest High School "Home of the Red Wolves"
Tolt Middle School "Home of the Thunderbirds"

PHYSICAL EXAMINATION FORM

PHYSICAL HISTORY QUESTIONNAIRE

	Yes	No	
1a	[ ]	[ ]	Have you had any illness/injury recently, or do you have an illness/injury now?
b	[ ]	[ ]	Have you had a medical problem, illness or injury since your last exam?
c	[ ]	[ ]	Do you have any chronic or recurrent illnesses?
d	[ ]	[ ]	Have you ever had any illness lasting more than a week?
e	[ ]	[ ]	Have you ever been hospitalized overnight?
f	[ ]	[ ]	Have you had any surgery other than a tonsillectomy?
g	[ ]	[ ]	Have you had any injuries requiring treatment by a physician?
h	[ ]	[ ]	Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
2	[ ]	[ ]	Are you presently taking any medications (including birth control, vitamin, aspirin, etc.)?
3	[ ]	[ ]	Do you have any allergies (medicines, bees, food, or other factors)?
4a	[ ]	[ ]	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
b	[ ]	[ ]	Do you tire more easily or quickly than your friends during exercise?
c	[ ]	[ ]	Have you ever had any problem with your blood pressure or your heart?
d	[ ]	[ ]	Have any relatives had heart problems, heart attack or sudden death before they were 50?
5	[ ]	[ ]	Do you have any skin problems (acne, itching, rashes, etc.)?
6a	[ ]	[ ]	Have you ever had fainting, convulsions, seizures, or severe dizziness?
b	[ ]	[ ]	Do you have frequent severe headaches?
c	[ ]	[ ]	Have you ever had a "stinger" or "burner" or "pinched nerve"?
d	[ ]	[ ]	Have you ever been knocked out or passed out?
e	[ ]	[ ]	Have you ever had a neck or head injury?
7	[ ]	[ ]	Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?
8	[ ]	[ ]	Have you had asthma, or trouble breathing, or coughing during or after exercise?
9a	[ ]	[ ]	Do you wear eyeglasses, contact lenses, or protective eye wear?
b	[ ]	[ ]	Have you had any problems with your eyes or vision?
10	[ ]	[ ]	Do you wear any dental appliance such as braces, bridge, plate, retainer, etc.?
11a	[ ]	[ ]	Have you ever had a knee injury?
b	[ ]	[ ]	Have you ever had an ankle injury?
c	[ ]	[ ]	Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
d	[ ]	[ ]	Have you ever had a broken bone or fracture?
e	[ ]	[ ]	Have you ever had a cast, splint, or had to use crutches?
f	[ ]	[ ]	Are you required to use special equipment for competition (pads, braces, neck roll, etc.)?
12	[ ]	[ ]	Has it been 5 or more years since your last tetanus shot? If so, when? ______________
13	[ ]	[ ]	Do you have any worries or concerns regarding your weight?
14	[ ]	[ ]	FEMALES: Have you any menstrual problems?
15	[ ]	[ ]	Have you any medical concerns about participating in your sport?

PHYSICAL EXAMINATION

Height: ______________ Weight: ______________ Blood Pressure: ______________

Pulse: ______________ Visual Acuity: Left 20/________ Right 20/________

Normal	Normal	Normal
[ ] 1) Head	[ ] 6) Heart	[ ] 11) Physical Maturity
[ ] 2) Eyes (pupils), ENT	[ ] 7) Abdomen	[ ] 12) Spine, Back
[ ] 3) Teeth	[ ] 8) Genitalia	[ ] 13) Shoulders, Upper extremities
[ ] 4) Chest	[ ] 9) Neuralgic	[ ] 14) Lower extremities
[ ] 5) Lungs	[ ] 10) Skin	[ ] 15) Other

Overall Assessment: [ ] Full Participation [ ] Limited Participation (explain) ______________________
[ ] Recommendations (equipment, taping, rehabilitation): ______________________

Wrestling / Recommend Weight Class: (103 /112 /119 /125 /130 /135 /140 /145 /152 /160 /171 /189 /215 /275)______________

DATE: ______/______/______

Examiner Physician Signature: ____________________ Printed Name ____________________ Phone ______________