ERAU WELLNESS CENTER PHYSICAL FORM

Name:_____ Sex: F M Phone: _____

STUDENT ID#_____ Box:_____

Date of Birth:_____ Age:_____

Check "Yes" or "No" answers as they apply:

1. Have you had a medical illness or injury since your last check up or sports physical? ☐ Yes ☐ No
2. Do you have an ongoing or chronic illness? ☐ Yes ☐ No
3. Have you been hospitalized overnight? ☐ Yes ☐ No
4. Have you ever had surgery? ☐ Yes ☐ No
5. Are you currently taking any prescription or non-prescription (over –the-counter) medications or pills or using inhaler? ☐ Yes ☐ No
6. Have you ever taken any supplements or vitamins to help gain or lose weight or improve your performance? ☐ Yes ☐ No
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? ☐ Yes ☐ No
8. Have you ever had a rash or hives develop during or after exercise? ☐ Yes ☐ No
9. Have you ever passed out during or after exercise? ☐ Yes ☐ No
10. Have you ever been dizzy during or after exercise? ☐ Yes ☐ No
11. Have you ever had chest pain during or after exercise? ☐ Yes ☐ No
12. Do you get tired more quickly than your friends do during exercise? ☐ Yes ☐ No
13. Have you ever had racing of your heart or skipped heartbeats? ☐ Yes ☐ No
14. Have you ever had high blood pressure or high cholesterol? ☐ Yes ☐ No
15. Have you ever been told you have a heart murmur? ☐ Yes ☐ No
16. Has any family member or relative died of heart problems or a sudden death before age 50? ☐ Yes ☐ No
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? ☐ Yes ☐ No
18. Has a physician ever denied or restricted your participation in sports for any heart problems? ☐ Yes ☐ No
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? ☐ Yes ☐ No
20. Have you ever had a head injury or concussion? ☐ Yes ☐ No
21. Have you ever been knocked out, become unconscious, or lost your memory? ☐ Yes ☐ No
22. Have you ever had a seizure? ☐ Yes ☐ No
23. Do you have frequent or severe headaches? ☐ Yes ☐ No
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet? ☐ Yes ☐ No
25. Have you ever had a stinging, burning, or a pinched nerve? ☐ Yes ☐ No
26. Have you ever become ill from exercising in the heat? ☐ Yes ☐ No
27. Do you cough, wheeze, or have trouble breathing during or after activity? ☐ Yes ☐ No
28. Do you have asthma? ☐ Yes ☐ No
29. Do you have seasonal allergies that require medical treatment? ☐ Yes ☐ No
30. Do you use any special protective or corrective equipment, or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? ☐ Yes ☐ No
31. Have you had any problems with your eyes or vision? ☐ Yes ☐ No
32. Do you wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
33. Have you ever had a sprain, strain, or swelling after injury? ☐ Yes ☐ No
34. Have you had broken or fractured any bones or dislocated any joints? ☐ Yes ☐ No
35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? ☐ Yes ☐ No

If yes, check appropriate box and explain below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

36. Do you want to weigh more or less than you do now. ☐ Yes ☐ No
37. Do you lose weight regularly to meet weight requirements for your sport? ☐ Yes ☐ No
38. Do you feel stressed out? ☐ Yes ☐ No
39. Record the dates of your most recent Tetanus shot? _____

FEMALES ONLY:

40. When age was your first menstrual period? _____
41. When was your last menstrual period? _____
42. Are your periods regular? ☐ Yes ☐ No
43. Have you missed any period in the last year? ☐ Yes ☐ No
44. Do you have severely painful periods? ☐ Yes ☐ No

Explain "Yes" answers:_____

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

Signature:_____ **Date:** _____