REGIS UNIVERSITY CLUB SPORTS PHYSICAL FORM

Name:	DOB: / /	Age:	Gender: Male/Female
Address:	Apt:	City:	State: Zip:
Email:			Phone:
Medical History:	Glasses/Contacts	Allergies	Medications:
Medical Conditions			
Additional Medical History	Circle One		Additional Notes:
Convulsions/head injury	YES	NO	
Prior Athletic Injuries	YES	NO	
Fractures/surgeries	YES	NO	
Heart Problems	YES	NO	
Asthma	YES	NO	
Serious or chronic illness	YES	NO	
Vitals			
Temperature:	BP: /	Pulse:	Respirations:
O2 Saturation: %	Height:	Weight:	Additional Notes:
Visual Acuity:	OU:	OS:	OS:
Exam:	Normal	Abnormal	Notes/Findings
Head/Face			
Eyes			
Ears/Nose/Throat			
Neck/Thyroid			
Respiratory			
Cardiovascular			
Vascular			
Abdomen			
Genitourinary			
Skin			
Musculoskeletal			
Neurological			
Psychiatric			
Based on today's exam this patient is cleared to participate: YES or NO If no, please state why and recommendations for further evaluation and/or treatment.			
Stamp:	Provider's Signature:		Date: