

Robert Teasdale Jr. M.D. Pre-Participation Physical Exam

1375 South Eliseo Drive, Greenbrae, CA 94904

415-461-4150 CaSptsMed@aol.com

Name _____ Age _____ Height _____ Weight _____

Birth date: _____ Social Security: _____

School: Drake Novato Redwood San Marin San Rafael Tam Terra Linda

Parent (Guardian) _____

Home Address: _____ City: _____ Phone: _____

Sport: Basketball Baseball Cheer Cross Country Football LaX Soccer Swim Track Volleyball Water polo

Medical History: (Please **circle** correct response)

Have you ever been treated for any of the following:

- Yes No Mononucleosis
- Yes No Pneumonia
- Yes No Asthma
- Yes No Rheumatic fever
- Yes No Scarlet fever
- Yes No Heart murmur
- Yes No Seizure
- Yes No Hepatitis
- Yes No Diabetes
- Yes No Sickle cell anemia
- Yes No High blood pressure
- Yes No Illness requiring rest for over 1 week in last year

If "yes" please provide dates and details _____

During the past 5 years, have you had any of the following conditions:

- Yes No I have exercised so hard that I have passed out
- Yes No I have felt my heart beat abnormally with hard exercise
- Yes No Knocked out
- Yes No Concussion
- Yes No Severe headaches
- Yes No Whiplash
- Yes No Pinched nerves
- Yes No Fracture of head or neck
- Yes No Sprain/strain of neck

If "yes" please provide dates and details _____

Have you had any of the following in the last 5 years?

- Yes No Fracture
- Yes No Shoulder or throwing arm injury
- Yes No Elbow or wrist injury
- Yes No Neck or low back injury
- Yes No Knee injury or Osgood-Schlatter's condition
- Yes No Shin splints or ankle injury
- Yes No Surgery

If "yes" please provide dates and details _____

Are you missing any body parts (e.g. kidney)? Yes No

Do you have dental braces? Y N Dental bridge? Y N False teeth? Y N

Do you see from both eyes? Y N Do you wear glasses during sports? Y N Contact lenses? Y N

Name: _____

Do you take prescribed medications? Y N Please list: _____

Do you have allergies to any of the following (please circle)

| | | |
|------------|--------------|--------------|
| Penicillin | Sulfa | Tetracycline |
| Codiene | Aspirin | Benzoin |
| Bee Stings | Other: _____ | |

Do you smoke tobacco? Y N Drink alcohol? Y N Use drugs? Y N

All of the above have been answered completely and truthfully to the best of my knowledge

Student: _____ Date: _____

Parent/Guardian: _____ Date: _____

M.D. PHYSICAL EXAM

Active medical illnesses: _____

Hospitalizations or surgery: _____

Current medication: _____

ROS

| | | | | |
|-----------|-----------------|----------------------|---------|----------|
| HEENT | Heart | Lungs | Stomach | Bleeding |
| Hepatitis | Kidney, Bladder | Exercise intolerance | | |

| | | | | | |
|----------------|-------|-------------|--------|-----|--------|
| Family History | Heart | Early Death | Stroke | HBP | Cancer |
| Father | _____ | | | | |
| Mother | _____ | | | | |
| Siblings | _____ | | | | |

EXAM Gen WNL _____ Pulse _____ BP ____/____ Ht _____ Wt _____

| | | |
|---|-------|----------|
| Skin: | _____ | WNL |
| Head, Neck: | _____ | WNL |
| Nodes: | _____ | WNL |
| Heart: Rhythm: reg irregular Murmurs | _____ | WNL |
| Lungs: Clear Wheeze | _____ | WNL |
| Abdomen: Tdr _____ Scars _____ Mass _____ | _____ | WNL |
| Genital: _____ Rectal _____ | _____ | Deferred |
| Neuro: Central _____ Perif _____ | _____ | WNL |
| Ortho: _____ | _____ | WNL |

Impression: Full Sports as requested Restrictions No sports

Follow up with _____

Robert Teasdale, M.D.
