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## Sports Physical Evaluation: Dexter

NAME: \_\_\_\_\_

MALE / FEMALE (Circle one).

AGE: \_\_\_\_\_ GRADE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_

**Circle the sports you play:**

Baseball	Basketball
Cheerleading	Cross-country
Field Hockey	Football
Softball	Track
Volleyball	Wrestling
Swimming	Diving
Golf	Soccer
Other	_____

**Instructions:** Please review all of the questions below and answer them as truthfully as possible. It is important to include all pertinent information. Parents or guardians must sign below.

- |  | Yes | No  | Explain     |
|--|-----|-----|-------------|
| 1. Has anyone in your family died suddenly before the age of 50?                             | ___ | ___ |             |
| 2. Have you ever passed-out or felt dizzy during exercise?                                   | ___ | ___ |             |
| 3. Do you have asthma or allergies?  | ___ | ___ |             |
| 4. Have you ever broken a bone, worn a cast, or injured a joint? (such as, an ankle or knee) | ___ | ___ |             |
| 5. Have you ever been knocked-out (concussion)?  | ___ | ___ |             |
| 6. Do you have a chronic illness or see a doctor regularly?                                  | ___ | ___ |             |
| 7. Do you have only one of any normally paired organ? (such as eyes, kidneys, etc.)          | ___ | ___ |             |
| 8. Do you consider your current weight ideal?<br>If no, write your ideal weight. _____ lbs.  | ___ | ___ |             |
| 9. Do you take any medications regularly?  | ___ | ___ | Please List |

**For Women Only:**

10. How old were you when you had your first period?  
\_\_\_\_\_ years
11. Do you have regular periods? \_\_\_ \_\_\_
12. How many periods did you have during the last 12 months? \_\_\_\_\_ number of periods

I have reviewed the above questions with my son or daughter and I give permission for my child to undergo the Pre-participation Physical Examination and to participate in sports.

Please Specify Health Insurance \_\_\_\_\_  
Hospital Preference \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# PHYSICAL EXAMINATION

**Physicians:** Please complete all the information below.

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

BP: \_\_\_\_\_

Vision:

(L) 20/\_\_\_\_\_ (R) 20/\_\_\_\_\_ (B) 20/\_\_\_\_\_

Corrected Y / N (circle one)

BP Reference Range:

10-12 y/o, > 125/80

13-15 y/o, > 135/85

16-18 y/o, > 140/90

Vision Reference Range: Is corrected or uncorrected vision better than 20/50 with both eyes?

Cardiopulmonary Examination:

Lungs

Pulses

Heart

Normal

Abnormal

Explain

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Musculoskeletal Screening:

Neck

Shoulder

Elbow

Wrist

Hand

Back

Knee

Ankle

Foot

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Other: (Physical examination pertinent to historical information)

Recommendation:

\_\_\_\_\_ 1. Pass

\_\_\_\_\_ 2. Pass with restrictions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ 3. Deferred until: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ 4. Failed, Reason: \_\_\_\_\_

\_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_