Medical-Physical Form

Personal Information

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: _____ Sex: _____ Ethnicity: _____ Height: _____ Weight: _____
Primary Physician: _____ Phone: _____
Insurance Provider: _____ ID No. _____

Current Symptoms (Check All That Apply)

☐ Headaches	☐ Joint Pain/Swelling	☐ Dizziness	☐ Numbness
☐ Nausea	☐ Vision Impairment	☐ Hearing Impairment	☐ Weight Loss/Gain
☐ Fevers	☐ Coughing/Wheezing	☐ Fatigue	☐ Chest/Back Pain

Medical History

Exercise Frequency: _____ Exercise Type(s): _____
Smoking Frequency: _____ Drinking Frequency: _____
Illicit Drug Frequency: _____ Fast Food Frequency: _____
Allergies: _____
Current Medications: _____
Current Diagnoses: _____
Current Injuries: _____
Previous Injuries: _____
Previous Medications: _____
Dates Treated: _____
Previous Medical Conditions: _____
Previous Surgeries:

Vaccinations

Standard Childhood Vaccinations	☐Yes	☐No	Date: _____
Hepatitis A	☐Yes	☐No	Date: _____
Hepatitis B	☐Yes	☐No	Date: _____
Tuberculosis	☐Yes	☐No	Date: _____
Flu	☐Yes	☐No	Date: _____
MMR	☐Yes	☐No	Date: _____
Td/Tdap	☐Yes	☐No	Date: _____
Chicken Pox (vaccine or illness)	☐Yes	☐No	Date:

Occupational Hazards

Do you require a respirator, face mask, or nose/mouth guard? _____
Will you be lifting more than fifty pounds on a regular basis? _____
Will you be exposed to human fluids (blood, feces, etc.)? _____
Will you be exposed to poisonous or radioactive chemicals? _____
Will you be operating heavy machinery/driving a vehicle?

_____ _____
Signature Date