

SOCIAL HISTORY

	Yes/No	Quantity Per Day		Yes/No	Quantity Per Day
Tobacco			Alcohol		

HOSPITALIZATIONS

Hospitalizations/Operations	Date

MEDICATIONS

Medication	Date

Please clarify any of the medical history (if necessary): _____

Signature

Date

Signature of Parent or Guardian*

Date

**If the applicant is under eighteen years of age, this form must also be signed by a parent or guardian*

PHYSICAL EXAMINATION

This section is to be completed by physician

Blood Pressure ____/____ Pulse ____ Resp. ____ Temp. ____ Height ____ft ____in Weight ____lbs

	<i>Normal</i>	<i>Abnormal</i>	<i>Findings</i>
General			
Head			
Eyes			
Acuity			OU / OS / OD /
Color Vision			
Ears			
Hearing			
Nose			
Mouth			
Neck			
Thorax			
Lungs			
Heart			
Pulses			
Abdomen			
Genitourinary			
Hernia			
Rectal			
Back/Spine			
Muscular-Skeletal			
Neurologic			
Dermatologic			

LABORATORY

	<i>Normal</i>	<i>Abnormal</i>	<i>Findings</i>
Thyroid Panel			
Urinalysis			
Blood Sugar			
HIV			
Drug			

Recommendations for physical activity (sports, etc.): Unlimited _____ Limited _____

Limitations _____

Recommendations regarding care of this applicant _____

Physician Name _____ Phone (_____) _____

Address _____

City/State/Zip/Country _____

Physician Signature _____ Date _____