UNC Health Campus Care at Carolina
James A. Taylor Building
320 Emergency Room Drive
Chapel Hill, NC 27599
P: 919-966-2281 | F: 919-966-0108

Tryout Physical

Name:_____ Home phone:_____

PID#:_____ Date of birth:_____

Sport this physical will be used for:_____

Answer questions as accurately as possible	Yes	No	Elaboration of yes answers
Have you ever had chest pain or abnormal heart beating with exercise?			
Has anyone in your family (grandparents, parents, brothers, sisters) died before the age of 50?			
Have you ever stopped exercising because you were dizzy or have you ever passed out during exercise?			
Have you ever been told you have a heart problem, murmur, high blood pressure or high cholesterol?			
Do you experience wheezing, difficult breathing, coughing or excessive fatigue while exercising?			
Have you ever broken a bone, dislocated a joint, or had to wear a cast? List type of injury/body part/date of injury:			
Have you ever had a concussion, head/neck/back injury, or tingling or numbness in your arms/legs?			
Have you ever had a heat-related illness (heat stroke, heat exhaustion) or had difficulty exercising in warm/hot weather?			
Have you had any surgeries or operations? List specifics of procedure(s) and date(s)			
Do you have a chronic illness, seizure history or see a doctor regularly for any particular problem?			
Are you taking any medications? List drug(s), dosage, times/day:			
Are you allergic to any medications or bee stings? List medications:			
Do you have only one of any paired organ (eyes, kidneys, testicles, ovaries, etc.)?			
Is there any family history of heart-related problems or Marfan's syndrome?			
Has a doctor ever told you to give up sports or limit your activity because of a health-related problem?			
Is there any significant recent illness or injury?			

I have read and agree with my answering of the above medical history questions.

Patient signature:_____ Date:_____

Parent signature:(if less than 18) _____ Date:_____

(over)

A. Vital statistics:

Height: _____ Weight: _____ Blood Pressure: _____ Heart Rate/Pulse: _____

B. Musculoskeletal exam:

	Normal	Abnormal	Record laxity, weakness, instability, decreased range of motion, or positive tests
NECK			
SHOULDER			
SPINE			
HIP			
KNEE			
ANKLE			
FEET			
OTHER			

C. Physician's exam:

	Normal	Abnormal	Comments
ENT			
HEART			
LUNGS			
ABDOMEN			
SKIN			
OTHER			

D. Physician's assessment and comments:

E. Recommendations:

1. Cleared: _____ 2. Not Cleared: _____ 3. Plan: _____

F. Physcian's signature:

Signature: _____ Date: _____

Name (print): _____ Phone Number: _____

G. Verification of sickle cell status—required for all sports except cheerleading
(Please attach copy of lab result. Documentation required.)

Sickle Cell Trait ____positive ____negative
(Note, if screening test is positive, please perform hemoglobin electrophoresis.)

UNC HEALTH®