



# Physical Evaluation

## History (Complete and review with your Family Physician)

Missionary Name	Gender	Date of Birth	Age	
<b>Explain "Yes answers below. Circle questions you don't know the answers to.</b>			<b>Yes</b>	<b>No</b>
1. Have you had a medical illness or injury since your last check up or physical?			<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?			<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?			<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?			<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or nonprescription (over-the-counter) medications or pills or using an inhaler?			<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?			<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?			<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?			<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?			<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?			<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?			<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?			<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?			<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?			<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?			<input type="checkbox"/>	<input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden death before age 50?			<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?			<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problems?			<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems for (example, itching, rashes, acne, warts, fungus, or blisters)?			<input type="checkbox"/>	<input type="checkbox"/>
7. Do you cough, wheeze, or have trouble breathing during or after activity?			<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma?			<input type="checkbox"/>	<input type="checkbox"/>
Do you have seasonal allergies that require medical treatment?			<input type="checkbox"/>	<input type="checkbox"/>

8.	Have you ever had a head injury or concussion? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span> Have you ever been knocked out, become unconscious, or lost your memory? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span> Have you ever had a seizure? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span> Do you have frequent or severe headaches? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span> Have you ever had numbness or tingling in your arms, hands, legs, or feet? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span> Have you ever had a stinger, burner, or pinched nerve? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span>
9.	Have you ever become ill from exercising in the heat? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span>
10.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span>
11.	Have you had any problems with your eyes or vision? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span> Do you wear glasses, contacts, or protective eyewear? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span>
12.	Have you ever had a sprain, strain, or swelling after injury? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span> Have you broken or fractured any bone, or dislocated any joints? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span> Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <i>If yes, check appropriate box and explain below.</i> <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 30%;"><input type="checkbox"/> Head</div> <div style="width: 30%;"><input type="checkbox"/> Elbow</div> <div style="width: 30%;"><input type="checkbox"/> Hip</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 30%;"><input type="checkbox"/> Back</div> <div style="width: 30%;"><input type="checkbox"/> Forearm</div> <div style="width: 30%;"><input type="checkbox"/> Thigh</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 30%;"><input type="checkbox"/> Chest</div> <div style="width: 30%;"><input type="checkbox"/> Wrist</div> <div style="width: 30%;"><input type="checkbox"/> Knee</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 30%;"><input type="checkbox"/> Shoulder</div> <div style="width: 30%;"><input type="checkbox"/> Hand</div> <div style="width: 30%;"><input type="checkbox"/> Shin/calf</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 30%;"><input type="checkbox"/> Upper arm</div> <div style="width: 30%;"><input type="checkbox"/> Finger</div> <div style="width: 30%;"><input type="checkbox"/> Ankle</div> </div> <div style="margin-top: 5px;"><input type="checkbox"/> Foot</div>
13.	Do you want to weigh more or less than you do now? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span>
14.	Do you feel stressed out? <span style="float: right;"><input type="checkbox"/></span> <span style="float: right;"><input type="checkbox"/></span>
15.	Record the dates of your most recent immunizations (shots) for: <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="width: 30%;">Tetanus</div> <div style="width: 30%;">Hepatitis A</div> <div style="width: 30%;">Measles</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="width: 30%;"></div> <div style="width: 30%;">Hepatitis B</div> <div style="width: 30%;">Chickenpox</div> </div>
<b>We hereby state that, to the best of our knowledge, our answers to the above questions are complete and correct.</b>	
<div style="display: flex; justify-content: space-between; padding: 5px;"> <span>Signature of missionary OR Signature of parent/guardian</span> <span>Date</span> </div>	

## Physical Examination (to be completed by physician/nurse practitioner/physician assistant)

Missionary Name		Gender	Date of Birth	Age		
Explain "Yes answers below. Circle questions you don't know the answers to.				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> </table>	Yes	No
Yes	No					
Name		Date of Birth				
Height	Weight	% Body Fat (optional)	Pulse	BP		
Vision R 20/ L 20/		Corrected: Y N		Pupils: Equal Unequal		

### Medical

Appearance
Eyes/Ears/Nose/Throat
Lymph Nodes
Heart
Pulses
Lungs
Abdomen
Genitalia (males only)
Skin

### Musculoskeletal

Neck
Back
Shoulder/arm
Elbow/forearm
Wrist/hand
Hip/thigh
Knee
Leg/Ankle
Foot

### Clearance

<input type="checkbox"/> Cleared <input type="checkbox"/> Cleared after completing evaluation/rehabilitation for: <input type="checkbox"/> Not cleared: Reason:	
Recommendation:	
Name of physician/**nurse practitioner/physician assistant (print/type)	
Date:	
Address:	Telephone:
Signature of physician/nurse practitioner/physician assistant	
MD/nurse practitioner/physician assistant	
Physician's Stamp:	