DEPARTMENT OF THE AIR FORCE
51st Medical Group (PACAF)
Unit 2060
APO AP 96278-2060

_____ HAS COMPLETED HIS/HER PHYSICAL EXAMINATION AND THE 51ST MEDICAL HOSPITAL PEDIATRIC CLINIC RECOMMENDS THE FOLLOWING:

_____ 1. PARTICIPATION IN PHYSICAL ACTIVITIES IS APPROVED

_____ 2. FURTHER ASSESSMENT IS NEEDED

THIS PHYSICAL IS APPROVED FOR THE PERIOD OF ONE YEAR FROM THE DATE OF EXAMINATION.

DATE _____

APPROVING AUTHORITY: 51ST MED. HOSPITAL, OSAN A.B.

SIGNED _____

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex_____ Age_____ Date of birth_____

Grade_____ School_____ Sport(s)_____

Address_____ Phone_____

Personal Physician _____

In case of emergency, contact:

Name_____ Relationship_____ Phone (H)_____ Phone(W)_____

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection	☐	☐
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period? _____		
49. How many periods have you had in the last 12 months? _____		

Explain "Yes" answers here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete_____ Signature of Parent/Guardian_____ Date_____

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Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____ / ____ (____ / ____, ____ / ____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.
+Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

Age:

	Yes	No
1. Do you have a chronic illness or see a physician regularly for any particular problem? 만성질병이나 어떠한 특별한 이유로 정기적으로 의사분 보고 있습니까?		
2. Have you ever had an illness that required you to stay in the hospital? 과거에 질병으로 인하여 입원에 입원한 적이 있습니까?		
3. Have you ever had surgery? 과거에 수술한 적이 있습니까?		
4. Have you ever broken a bone, had to wear a cast, or had an injury to any joint? 과거에 골절을 당해 깁스를 하거나 혹은 관절을 다친 적이 있습니까?		
5. Are you missing any organs? (eye, kidney, testicle) 신체 기관 중 없는 것이 있습니까? (눈, 신장, 또는 고환)		
6. Have you ever passed out during exercise or stopped exercising because of dizziness or chest pain? 과거에 운동이나 어지러움 때문에 운동을 그만 두었거나 혹은 운동하는 동안 쓰러진 적이 있습니까?		
7. Have you ever had a heat related illness? 과거에 열과 관련된 병을 앓은 적이 있습니까?		
8. Have you ever had a concussion? 과거에 뇌진탕이 있었던 적이 있습니까?		
9. Do you have asthma, hay fever or coughing spells after exercise? 운동한 후 심한 기침이나 고초열, 천식을 갖습니까?		
10. Have you ever had a heart murmur, high blood pressure, or a heart abnormality? 과거에 심장의 작은 고혈압 혹은 심장의 비정상적인 문제가 있었습니까?		
11. Do you wear glasses or contact lenses? 안경이나 렌즈를 착용하십니까?		
12. Do you wear dental bridges, braces, or plates? 치아에 보조기구를 착용하십니까?		
13. Have any members of you family under age 50 had a heart attack, heart problem, or died unexpectedly? 가족 중 나이 50세 이상으로 심장 마비나 어떠한 심장질환 혹은 갑작스런 사망을 했던 사람이 있습니까?		
14. Do you take any medications? List medications below include dose and frequency. 복용하고 있는 약이 있습니까? 있다면 약의 이름들을 용법, 횟수와 함께 목록으로 기록하십시오.		
15. Are you allergic to any medication? 어떤 약에 대한 알레지가 있습니까?		

Explain any "Yes" answers in the space below.
여라고 대답했을 경우에 그에 대한 설명을 아래 빈칸에 쓰세요.

Date of: Last tetanus 2nd MMR Last PPD

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

Home phone:

Duty phone:

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505