DEVILPUPS
YOUTH PROGRAM FOR AMERICA

Physical Examination

To be completed and signed by physician

Patient Information:

Name _____ Birth Date _____ Age _____

Date of Exam _____ HS Grade _____ Sex: Male _____ Female _____

Prior Injuries: ☐Yes or ☐No (If Yes, complete below. Attach a second page if needed)

Date	Injury

Date	Injury

Hospitalizations: ☐Yes or ☐No (If Yes, complete below. Attach a second page if needed)

Date	Reason

Date	Reason

Surgical procedures: ☐Yes or ☐No (If Yes, complete below. Attach a second page if needed)

Date	Reason

Date	Reason

Allergies: ☐Yes or ☐No (If Yes, complete below. Attach a second page if needed)

Bee stings ☐Yes or ☐No If Yes: Medication taken. _____

Food ☐Yes or ☐No If Yes: What type of food? _____

Medications ☐Yes or ☐No If Yes: List. _____

Other List. _____

Mental Health: Conditions Present (Mark Yes or No and complete)

Anxiety ☐Yes or ☐No If Yes: ☐Mild ☐Moderate ☐Severe Medications _____

Depression ☐Yes or ☐No If Yes: ☐Mild ☐Moderate ☐Severe Medications _____

ADHD ☐Yes or ☐No If Yes: ☐Mild ☐Moderate ☐Severe Medications _____

Current medications: (Attach a second page if needed)

Medication Name	Dose	Frequency	Diagnosis	Physician Specialty	Date Prescribed

Menstruation is present and normal? ☐Yes ☐No ☐N/A

General Appearance and Vital Signs:

Blood Pressure _____ /_____ Pulse _____ Respirations _____ Temp _____ Height _____ Weight _____

Evaluation of Systems:

System Name	Normal Findings?		System Name	Normal Findings?	
Skin	Yes	No	Heart	Yes	No
Head/Face	Yes	No	Abdomen	Yes	No
Eyes	Yes	No	Liver	Yes	No
Ears	Yes	No	Spleen	Yes	No
Nose	Yes	No	Hernia	Yes	No
Mouth/Throat	Yes	No	Extremities	Yes	No
Neck	Yes	No	Sensory Abilities	Yes	No
Lymph Node	Yes	No	Balance	Yes	No
Thyroid	Yes	No	Posture	Yes	No
Chest/Lungs	Yes	No	Flexibility/Joints	Yes	No
Describe Abnormal Findings Here					

_____ _____ _____

Name of Physician (please print) Physician's Signature Date

Physician Address: _____ Physician Phone Number: _____