DEVILPUPS
YOUTH PROGRAM FOR AMERICA

Physical Examination Form

To be completed and signed by physician

Patient Info:

Name _____ Birth Date _____ Age _____

Date of Examination _____ High School Grade ☐9 ☐10 ☐11 ☐12 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?	
Skin	☐Yes	☐No
Head/Face	☐Yes	☐No
Eyes	☐Yes	☐No
Ears	☐Yes	☐No
Nose	☐Yes	☐No
Mouth/Throat	☐Yes	☐No
Neck	☐Yes	☐No
Lymph Node	☐Yes	☐No
Thyroid	☐Yes	☐No
Chest/Lungs	☐Yes	☐No

System Name	Normal Findings?	
Heart	☐Yes	☐No
Abdomen	☐Yes	☐No
Liver	☐Yes	☐No
Spleen	☐Yes	☐No
Hernia	☐Yes	☐No
Extremities	☐Yes	☐No
Sensory Abilities	☐Yes	☐No
Balance	☐Yes	☐No
Posture	☐Yes	☐No
Flexibility/Joints	☐Yes	☐No

Describe abnormal findings here

_____ _____ _____

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

Physician Address: _____ Physician Phone Number: _____