**PHYSICAL EXAMINATION**

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_/\_\_\_/\_\_\_\_\_\_\_ Date of Exam: \_\_\_/\_\_\_/\_\_\_\_\_\_\_

**A PHYSICAL EXAM IS REQUIRED BY ALL STUDENTS ENTERING WILLIAMS COLLEGE,** *including all new undergraduate, graduate and transfer students.*

Students are not eligible to participate in any Williams College sports programs, including intramural and club sports, until this form has been completed and submitted to Health Services. The athletic trainer may have access to the physical examination report of students who elect to participate in athletics.

**All Varsity and Junior Varsity Athletes** must have had a physical **within the 6 month period** preceding their sport season**.**The following dates indicate the start of the sport season: **Fall – August 30**; **Winter and Spring – November 1**.

# **HISTORY** PLEASE ANSWER ALL QUESTIONS AND PROVIDE ALL PHYSICAL DATA REQUESTED ON THE FORM

|  |  |  |
| --- | --- | --- |
|  | **YES**  | **NO**  |
| Prior exertional chest pain  |  |  |
| Prior exertional syncope/ near syncope  |  |  |
| Excessive, unexplained shortness of breath or fatigue with exercise  |  |  |
| Prior history of heart murmur of increased blood pressure  |  |  |
| Family history of premature death or mortality from cardiovascular disease in a relative younger than age 50  |  |  |
| Occurrence in family, specifically hypertrophic cardiomyopathy or dilated cardiomyopathy, long QT syndrome or Marfan’s syndrome  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **SYSTEM**  |  **or describe findings**  |  | **DESCRIBE ABNORMALITY**  |
| Heart/Vascular System:  |  |  |  |
|  Blood Pressure (enter value)  | \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  |   |  |
|  Precordial Auscultation  | No murmur, RRR   |   |  |
|  Femoral Pulses  | Present and Equal   |   |  |
|  Marfan’s syndrome  | No signs/stigmata   |   |  |
|  |  |  **IF NORMAL**  |  |
| Skin  |  |   |  |
| HEENT  |  |   |  |
| Lungs/Chest  |  |   |  |
| Breasts  |  |   |  |
| Abdomen (rectal if indicated)  |  |   |  |
| Genito-urinary  |  |   |  |
| Pelvic (if indicated)  |  |   |  |
| Lymphatic  |  |   |  |
| Musculoskeletal  |  |   |  |
| Neurological  |  |   |  |
| Endocrine  |  |   |  |
| Psychological  |  |   |  |
| **Unlimited Physical Activity**  |  **Yes**  **No**  |  **DO NOT LEAVE THIS BLANK**  |

**Height** \_\_\_\_\_\_ft\_\_\_\_\_\_in **Weight** \_\_\_\_\_\_\_\_\_\_\_lbs **BMI**\_\_\_\_\_\_\_\_\_

**NCAA REQUIRES SICKLE CELL TESTING OR SIGNED WAIVER FOR ALL ATHLETES –** if testing is declined, education & waiver is done after arrival on campus by Athletics Department. **SICKLE CELL (HgbAS) trait status** (check one):  AS positive  AS negative  Declines Test

**Lab work recommended:** Hgb/Hct\_\_\_\_\_\_\_\_\_\_\_\_ Cholesterol\_\_\_\_\_\_\_\_\_\_ HDL\_\_\_\_\_\_\_\_\_\_ LDL\_\_\_\_\_\_\_\_\_\_ Urine: Glucose\_\_\_\_\_\_\_\_\_\_ Protein\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **CURRENT MAJOR AND CHRONIC PROBLEMS**  | **ACUTE OR MINOR PROBLEMS**  |
|  |  |

**IF THE STUDENT IS UNDER CARE FOR A CHRONIC CONDITION OR SERIOUS ILLNESS, PLEASE PROVIDE ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.**

**ALLERGIES** (medications, insect venom, foods, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS** (include vitamins, oral contraceptives, Rx, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any dietary recommendations?**  Yes  No Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please note any additional recommendation regarding this student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Health Care Provider** (Not a relative; Please Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Provider’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | Completed forms should be uploaded to the Williams College Ephs Patient Portal*https://williams.medicatconnect.com* **by July 1** |