

**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.**

**ALL QUESTIONS MUST BE ANSWERED AND PLEASE PROVIDE ALL PHYSICAL DATA REQUESTED ON THE FORM**

<b>HISTORY</b>	<b>YES</b>	<b>NO</b>
Prior exertional chest pain		
Prior exertional syncope/ near syncope		
Excessive, unexplained shortness of breath or fatigue with exercise		
Prior history of heart murmur or 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		

<b>SYSTEM</b>	<b>✓ or describe findings</b>	<b>DESCRIBE ABNORMALITY</b>
Heart/Vascular System:		
Blood Pressure (enter value)	_____/_____	
Precordial Auscultation	No murmur, RRR <input type="checkbox"/>	
Femoral Pulses	Present and Equal <input type="checkbox"/>	
Marfan's syndrome	No signs/stigmata <input type="checkbox"/>	
		✓ <b>IF NORMAL</b>
Skin		<input type="checkbox"/>
HEENT		<input type="checkbox"/>
Lungs/Chest		<input type="checkbox"/>
Breasts		<input type="checkbox"/>
Abdomen (rectal if indicated)		<input type="checkbox"/>
Genito-urinary		<input type="checkbox"/>
Pelvic (if indicated)		<input type="checkbox"/>
Lymphatic		<input type="checkbox"/>
Musculoskeletal		<input type="checkbox"/>
Neurological		<input type="checkbox"/>
Endocrine		<input type="checkbox"/>
Psychological		<input type="checkbox"/>
<b>Unlimited Physical Activity</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>← DO NOT LEAVE THIS BLANK</b>

**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 \_\_\_\_\_

<b>CURRENT MAJOR AND CHRONIC PROBLEMS</b>	<b>ACUTE OR MINOR PROBLEMS</b>

**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:** \_\_\_\_\_

<b>Health Care Provider</b> (Not a relative; Please Print): _____ <b>Address:</b> _____ <b>Phone:</b> (_____) _____ <b>Fax:</b> (_____) _____ <b>Provider's Signature:</b> _____ <b>Date:</b> _____	Completed forms should be uploaded to the <i>Williams College</i> <i>Ephys Patient Portal</i> <a href="https://williams.medicalconnect.com">https://williams.medicalconnect.com</a> <b>by July 1</b>
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