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To be filled out by parent/guardian:

Please complete before Physical

Patient name: _____ Date of Birth: _____ Phone: _____

Medications taken daily: _____ Allergies: _____

Personal History (circle "Y" for yes and "N" for no)

- | | | |
|--|---|---|
| 1) Chest pain/discomfort upon exertion | Y | N |
| 2) Unexplained fainting | Y | N |
| 3) Unexplained fatigue associated with exercise | Y | N |
| 4) History of heart murmur | Y | N |
| 5) History of high blood pressure | Y | N |
| 6) History of Asthma | Y | N |
| 7) Girls: Last menstrual period _____ | | |
| 8) Any other medical problems or concerns? _____ | | |

Family History:

- | | | |
|---|---|---|
| 1) Any relatives die of heart disease before age 50 | Y | N |
| 2) Heart problems in family members? | Y | N |

To be filled out by medical provider: (circle "N" for normal and "ABN" for abnormal)

HT: _____ WT: _____ B/P: _____ Temp: _____ HR: _____ Resp: _____

Appearance	N	ABN	Groin	N	ABN
HEENT	N	ABN	Extremities	N	ABN
Chest	N	ABN	Skeletal/muscle	N	ABN
CV	N	ABN	Back	N	ABN
Abdomen	N	ABN	Neuro	N	ABN

Assessment: 1) Well Child 2) _____ 3) _____

- Plan: Okay to participate in sports without restrictions
 Okay to participate in sports with the following restrictions: _____
 Restricted from participating until sees primary care provider for: _____

Date: _____ Providers Signature: _____