CADET INITIAL ENTRY TRAINING (CIET) – MEDICAL

OPERATIONS PRE-PARTICIPATION PHYSICAL FORM - ***MEDICAL HISTORY FORM***

DATE OF EXAM: ____/____/____

Name (Print:) _____Gender: ☐ Male ☐ Female

Age: ____ Date of birth: ____/____/_____

Are you now or have you ever been treated for any of the following:

	YES	NO	EXPLAIN
Asthma	☐	☐	
Diabetes	☐	☐	
Hypertension (high blood pressure)	☐	☐	
Heart Condition	☐	☐	
Skipped or irregular heart beats	☐	☐	
Migraine Headaches	☐	☐	
Ear/Sinus problems/ear tubes	☐	☐	
Heat Injury/stroke/rhabdomyolysis	☐	☐	
Psychiatric/psychological and emotional difficulties	☐	☐	
Learning Disorders (i.e. ADHD, ADD)	☐	☐	
Bleeding disorders	☐	☐	
Fainting spells/passed out/head injury	☐	☐	
Thyroid Disease	☐	☐	
Kidney Disease	☐	☐	
Sickle Cell Disease	☐	☐	
Seizures	☐	☐	
Sleep disorders (i.e. sleep apnea)	☐	☐	
GI Problems (i.e. abdominal, digestive)	☐	☐	
Surgery List when and what type:	☐	☐	
Serious injury/concussion When and what:	☐	☐	
Mononucleosis	☐	☐	
Have you ever had an injury (e.g. sprained muscle or ligament tear, or tendonitis, that caused you to miss an athletic event) If yes, circle affected area below:	☐	☐	
Have you had any fractured bones or dislocated joints? If yes, circle below:	☐	☐	
Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, Physical Therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐	

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

FEMALES ONLY	
Have you ever had a menstrual period ☐ ☐	
How old were you when you had your first menstrual period?	AGE:
How many periods have you had in the last 12 months	#

Allergies:

MEDICATIONS:
List all medications currently used. (If additional space is needed, please photo copy this part of the health form.)
Inhalers and EpiPen Information must be included, even if they are for occasional or emergency use only.

Medication:

Strength: _____Frequency_____
Reason for medication:

Date Started _____
Temporary ☐ Permanent ☐

Medication:

Strength: _____Frequency_____
Reason for medication:

Date Started _____
Temporary ☐ Permanent ☐

Medication:

Strength: _____Frequency_____
Reason for medication:

Date Started _____
Temporary ☐ Permanent ☐

Medication:

Strength: _____Frequency_____
Reason for medication:

Date Started _____
Temporary ☐ Permanent ☐

Medication:

Strength: _____Frequency_____
Reason for medication:

Date Started _____
Temporary ☐ Permanent ☐

Be sure to bring medications in the original containers and make sure they are NOT expired, including inhalers and EpiPens (approved). You SHOULD NOT STOP taking any maintenance medications.
If applicable, ensure you bring two pairs of glasses and prescription.

CADET INITIAL ENTRY TRAINING (CIET) – MEDICAL OPERATIONS PRE-PARTICIPATION PHYSICAL FORM - ***MEDICAL HISTORY FORM***

Name (Print): _____ Date of birth: _____

Height: _____ Weight: _____ Meets Height/Weight Limits ☐ Yes ☐ No Pulse: _____ BP: _____ / _____ (_____ / _____)

Vision R 20/ _____ L 20/ _____ Corrected: □ YES □ NO Pupils : □ EQUAL □ UNEQUAL

	NORMAL	ABNORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL				
Eyes	□	□		
Ears	□	□		
Nose	□	□		
Throat	□	□		
Pulses	□	□		
Lungs	□	□		
Heart	□	□		
Abdomen	□	□		
Skin	□	□		
Genitalia (males only) **	□	□		
Inguinal Hernia	□	□		
Emotional Adjustment	□	□		
MUSCULOSKELETAL				
Neck	□	□		
Back	□	□		
Shoulder/arm	□	□		
Elbow/forearm	□	□		
Wrist/hand	□	□		
Hip/thigh	□	□		
Knee	□	□		
Leg/ankle	□	□		
Foot	□	□		
OTHER				
Glasses (contacts)	□	□		
Braces	□	□		
	□	□		

Allergies (to what agent, type of reaction, treatment)

_____

_____

_____

_____

I certify that I have, today, reviewed the health history, examined this person and approved this individual for participation in:

□ CIET Cleared without restriction

□ CIET Cleared with recommendations for further evaluation or treatment for:

_____

□ Not cleared for: □ Physical Fitness Activities, □ Specific Activities:

_____

Reason:

_____

_____

HCP Printed Name_____
MD / DO / NP / PA-C

Signature:_____

Address: _____

City, State, Zip_____

Office Phone: _____

Date: _____

HT/WT Standards		MAX	MAX	MAX	MAX
HT (inches)	Minimum WT	Male age 17-20	Male age 21-27	Female Age 17-20	Female Age 21-27
58	91			122	124
59	94			127	128
60	97	139	141	132	134
61	100	144	146	136	137
62	104	148	150	140	141
63	107	153	155	145	147
64	110	158	160	149	151
65	114	163	165	154	156
66	117	168	170	160	160
67	121	174	176	163	166
68	125	179	181	168	171
69	128	184	186	173	176
70	132	189	192	178	181
71	136	194	197	183	186
72	140	200	203	189	191
73	144	205	208	194	196
74	148	211	214	199	203
75	152	217	220	205	208
76	156	223	226	210	213
77	160	229	232	216	219
78	164	235	238	222	224
79	168	241	244	227	230
80	173	247	250	233	236