ARCA

History & Physical

Date of Exam: _____

Last Name: _____ First Name _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone #: _____ Shop / Work #: _____

Cell Phone #: _____ Email address: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced Series Competing in: ◯ ARS ◯ Other: _____

Car/Truck #: _____ Car/Truck Owner: _____ Team Name: _____

In case of a medical emergency, list two emergency contacts:

Name: _____ Relationship: _____ Home/Cell Phone: _____

Name: _____ Relationship: _____ Home/Cell Phone: _____

List medications currently taking including non-prescription drugs

Medication Name	Dosage	How Often

Medication Name	Dosage	How Often

Allergies: List any allergies including medications, food, x-ray dye: _____ ◯ No known allergies

Have you ever been treated for any illness, injury or surgery: ◯ Yes ◯ No

List reason for hospitalization and date: _____

Have you ever been treated for, had or have any of the following?
Yes responses should be explained below:

Concussion or head injury	◯ Yes	◯ No		Heart attack or irregular heart beat	◯ Yes	◯ No	
Frequent or severe headaches	◯ Yes	◯ No		High blood pressure	◯ Yes	◯ No	
Unconsciousness for any reason	◯ Yes	◯ No		Diabetes	◯ Yes	◯ No	
Dizziness or fainting	◯ Yes	◯ No		Anemia or blood disease	◯ Yes	◯ No	
Epilepsy or seizures	◯ Yes	◯ No		Lung problems	◯ Yes	◯ No	
Stroke or TIA	◯ Yes	◯ No		Asthma	◯ Yes	◯ No	
Eye trouble	◯ Yes	◯ No		Anesthesia complications	◯ Yes	◯ No	
Loss of vision	◯ Yes	◯ No		Stomach problems	◯ Yes	◯ No	
Lasix surgery	◯ Yes	◯ No		Ulcers	◯ Yes	◯ No	
Ear, nose or throat problems	◯ Yes	◯ No		Bowel problems	◯ Yes	◯ No	
Thyroid problems	◯ Yes	◯ No		Broken bones	◯ Yes	◯ No	
Back, neck or spine problems	◯ Yes	◯ No		Joint or muscle problems	◯ Yes	◯ No	
Heart trouble	◯ Yes	◯ No		Implanted metal plates	◯ Yes	◯ No	
Coronary artery disease	◯ Yes	◯ No		Pins or screws	◯ Yes	◯ No	
Valve disease	◯ Yes	◯ No		Amputations, physical disability	◯ Yes	◯ No	
Angina	◯ Yes	◯ No		Admission to hospital past year	◯ Yes	◯ No	

Explain yes answers: _____

_____

Date of last Tetanus shot: _____ ◯ Unknown ◯ None **Do you have a regular Physician?:** ◯ Yes ◯ No

Name: _____ **Phone #:** _____

Physician address: _____

Form completed by _____ Relationship _____

GENERAL PHYSICAL EXAM

Patient name: _____ SS #: _____

Height: _____ Weight: _____ Temperature: _____ Pulse / Rhythm: _____ BP _____ RR _____
Today's actual weight

Date		Physical Exam
		General Appearance
		◯ Skin
		◯ Head
		◯ Eyes
		◯ ENT
		◯ Lymph Nodes
		◯ Thyroid
		◯ Breasts
		◯ Peripheral Vessels
		◯ Heart
		◯ Lungs
		◯ Abdomen
		◯ Pelvis
		◯ Spine
		◯ Joints
		◯ Extremities
		◯ Gait
		◯ Mental Status
		◯ Neuro

Snellen Visual Acuity

	WITHOUT CORRECTION	WITH CORRECTION
OS		
OD		
OU		

Do you wear?	Yes	No
Contact lenses	◯	◯
Contact lenses while driving race car/truck	◯	◯
Corrective glasses	◯	◯
Corrective glasses while driving race car/truck	◯	◯
Corrective sunglasses while driving race car/truck	◯	◯
Dentures	◯	◯
Partials	◯	◯

The undersigned physician has reviewed the patient's medical history and conducted a physical examination on the patient. As a result of that review and examination the physician finds no signs or symptoms that would preclude the patient from participating in motor vehicle racing.

_____ Phone #: _____
Print Physician's Name

Address: _____ _____
Examining Physician Signature

_____ Date Signed: _____