



Department of Veterans Affairs

GENERAL MEDICAL FORM

TO BE COMPLETED BY PARTICIPANT. PLEASE TYPE OR PRINT CLEARLY.

PRIVACY ACT: VA is asking you to provide the information on this form under USC, Chapter 5, Section 521 and Chapter 17, Section 1710. VA may disclose the information that you put on this form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 121VA19 "National Patient Databases - VA". Providing the requested information is voluntary. However, you will not be able to participate in the event without furnishing this information.

RESPONDENT BURDEN: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

DATE		VA MEDICAL CENTER NAME		
NAME (Last, First, MI)		ADDRESS (Street, City, State, Zip Code)		
E-MAIL ADDRESS				
SOCIAL SECURITY NO. (Last 4 digits only)	AGE	DAYTIME TELEPHONE NUMBER (Include area code)	CELL PHONE NUMBER (Include area code)	EVENING TELEPHONE NUMBER (Include area code)
TEAM COORDINATOR/LEADER: _____		ALTERNATE TEAM CONTACT: _____		
TELEPHONE NUMBER	E-MAIL ADDRESS	TELEPHONE NUMBER	E-MAIL ADDRESS	
In Case of Emergency, Notify (Name):		ADDRESS (Street, City, State and Zip Code)		
TELEPHONE NUMBER	RELATIONSHIP TO PATIENT			

TO BE COMPLETED BY THE EXAMINING PHYSICIAN. PLEASE TYPE OR PRINT CLEARLY.

Dear Doctor: Your detailed exam of the participant will be very helpful to the medical assistance team. If an assistant completes the form, please countersign the exam.

OPERATIONS (Please list) 1 _____ 2 _____ 3 _____	ALLERGIES (Are you allergic to anything? If yes, specify) <input type="checkbox"/> YES <input type="checkbox"/> NO 1 _____ 2 _____ 3 _____
DIAGNOSIS/TYPE OF INJURY DATE OF INJURY OR DIAGNOSIS _____ <input type="checkbox"/> SPINAL CORD INJURY (SCI)--LEVEL OF INJURY _____ <input type="checkbox"/> MULTIPLE SCLEROSIS (MS) <input type="checkbox"/> AMPUTEE <input type="checkbox"/> HEAD INJURY <input type="checkbox"/> OTHER (Please specify) _____	VA IDENTIFICATION CARD <div style="border: 2px solid black; padding: 10px; text-align: center;"> <p>PLEASE ATTACH A COPY OF VA IDENTIFICATION CARD HERE (See below)</p> </div> <p>If you do not attach a copy of your VA IDENTIFICATION CARD you must fill out VA Form 10-10EZ including your full Social Security Number.</p>

MEDICATIONS (Please list all medications you are currently using. If you require more room, please attach an additional sheet.)		
MEDICATION NAME	DOSAGE	HOW OFTEN TAKEN
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____

OTHER MEDICAL INFORMATION (Please list all other medical information concerning your current health status.) 1 _____ 2 _____

PHYSICAL FORM

WEIGHT	BLOOD PRESSURE	HEAD & NECK	LUNGS	ABDOMEN
HEART	EXTREMITIES	SKIN	OTHER FINDINGS	

PRESENT AND PAST MEDICAL HISTORY (*Diabetes, heart disease, hypertension, etc.*)

IS THE PATIENT ON DIALYSIS?* (*Patient is responsible for setting up any dialysis treatment needed*) YES NO

IS THE PATIENT ON A VENTILATOR? YES NO

IS THE PATIENT ON ANTICOAGULANT DRUGS? (*If yes, which*) YES NO

PHYSICIAN CLEARANCE
 IN MY OPINION, THE ABOVE INDIVIDUAL (*You must check one of the following boxes*)

IS CLEARED TO COMPETE OR IS NOT CLEARED TO COMPETE

IF NOT CLEARED, REASON WHY

PHYSICIAN INFORMATION

NAME OF EXAMINING PHYSICIAN (*Please print*)

ADDRESS (*Street, City, State and Zip Code*)

SIGNATURE OF EXAMINING PHYSICIAN

TELEPHONE NUMBER DATE

NVWG AND/OR USQRA CLASSIFICATION CARD(S)

PLEASE ATTACH A COPY OF YOUR CLASSIFICATION CARD(S)
(See below)

If applicable, please attach a **copy** (not the original) of you National Veterans Wheelchair Games, USQRA (quad rugby), and/or Wheelchair Sports, USA classification card above.

May omit only if copy of current NVWG Classification card is stapled in the area provided in the General Medical Information Section on Page 1 of this form.

This section must be completed by someone familiar with direct muscle testing, i.e., a physician, physical therapist, kinesiologist, or occupational therapist.

NEURO EXAM (*Manual muscle test, 0-5*)

UPPER EXTREMITY	RIGHT	LEFT	LOWER EXTREMITY	RIGHT	LEFT
DELTOID	_____	_____	HIP FLEXION	_____	_____
BICEPS	_____	_____	HIP EXTENSION	_____	_____
WRIST EXTENSION	_____	_____	HIP ADDUCTION	_____	_____
WRIST FLEXION	_____	_____	HIP ABDUCTION	_____	_____
TRICEPS	_____	_____	KNEE FLEXION	_____	_____
FINGER EXTENSION	_____	_____	KNEE EXTENSION	_____	_____
FINGER FLEXION	_____	_____	DORSIFLEXION	_____	_____
FINGER ABD/ADD	_____	_____	PLANTARFLEXION	_____	_____

<p>SITTING BALANCE (<i>Please check one</i>)</p> <p><input type="checkbox"/> NORMAL <input type="checkbox"/> FAIR</p> <p><input type="checkbox"/> POOR <input type="checkbox"/> NONE</p>	<p>HANDEDNESS (<i>Please check one</i>)</p> <p><input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT</p>	<p>TRUNK (<i>0-5 scale</i>)</p> <table style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">UPPER</td> <td style="text-align: center;">LOWER</td> </tr> <tr> <td>ABDOMINALS</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>SPINAL EXTENSORS</td> <td>_____</td> <td>_____</td> </tr> </table>		UPPER	LOWER	ABDOMINALS	_____	_____	SPINAL EXTENSORS	_____	_____
	UPPER	LOWER									
ABDOMINALS	_____	_____									
SPINAL EXTENSORS	_____	_____									