



INTERNATIONAL HOT ROD ASSOCIATION  
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 NORWALK, OHIO 44857  
 PHONE: 419-663-6666 FAX: 419-668-6601

### MEDICAL PHYSICAL FORM

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (For each "yes" checked describe conditions in remarks)

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
		a. frequent or severe headaches			g. heart trouble			m. nervous trouble of any sort			s. medical rejection from service
		b. dizziness or fainting spells			h. high or low blood pressure			n. any drug or narcotic habit			t. admission to hospital
		c. unconsciousness for any reason			i. stomach trouble			o. excessive drinking habit			u. rejection for life insurance
		d. eye trouble except glasses			j. kidney stone or blood in urine			p. attempted suicide			v. record of traffic convictions
		e. hay fever			k. sugar or albumin in urine			q. motion sickness requiring drugs			w. record of other convictions
		f. asthma			l. epilepsy or fits			r. military medical discharge			x. other illnesses

**REMARKS:** (if no changes since last report, so state) \_\_\_\_\_

### MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS

Date	Name of Physician Consulted	Reason

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

**APPLICANTS' DECLARATION:** *I hereby certify that all statements and answers provided by me in this examination form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for insurance of any IHRA certificate to me.*

**REPORT OF MEDICAL EXAMINATION**

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE BOX
		1. Head, face, neck and scalp
		2. Nose
		3. Sinuses
		4. Mouth and throat
		5. Ears, general (internal and external canals)
		6. Ear Drums (perforation)
		7. Eyes, general (visual activity under items 50 &51)
		8. Ophthalmoscopic
		9. Pupils (equality and reaction)
		10. Ocular mobility (associated parallel movement, mystaginus)
		11. Lungs and chest (including breasts)
		12. Heart ( thrust, size, rhythm, sounds)
		13. Vascular system
		14. Abdomen and viscera (including hernia)
		15. Anus and rectum (hemorrhoids, fistula, prostate)
		16. Endocrine system
		17. G-U system
		18. Upper and lower extremities ( strength, range of motion)
		19. Spine other musculoskeletal
		20. Identifying body marks, scar, tattoos
		21. Skin and lymphatic
		22. Neuralgic (tendon reflexes, equilibrium, senses, coordination)
		23. Psychiatric (specify any personality deviation)
		24. General Systemic

**NOTES:** Describe every abnormality in detail, enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

HEARING		RIGHT EAR				LEFT EAR				DISTANT VISION		NEAR VISION			
Whispered voice Standing sideways Distant ear closed	Audiometer (decibel loss)	<b>FT</b>				<b>FT</b>				<b>Right eye</b>	20/	20/			
		50	1000	2000	4000	50	1000	2000	4000	<b>Left eye</b>	20/	20/			
										<b>Both eyes</b>	20/	20/			
<b>INTRAOCULAR TENSION</b>						<b>COLOR VISION</b> (test used, number of plates missed)									
	<b>TACTILE</b>	<b>RIGHT EYE</b>		<b>LEFT EYE</b>											
	<b>TONOMETRIC</b>														
<b>FIELD OF VISION</b>						<b>HETEROPHORIA DIOPTERS</b> (not required for class three)									
RIGHT EYE		LEFT EYE				DISTANCE		ESOPHORIA		EXOPHORIA		RIGHT H.		LEFT H.	
<b>BLOOD PRESSURE</b>						<b>PULSE (Wrist)</b>									
Recumbent MM Mercury	Systolic		Diastolic		Resting		After Exercise		2 minutes after exercise						
<b>URINALYSIS</b>				<b>ECG (Date)</b>		<b>OTHER TESTS</b>									
Albumen		Sugar													

**COMMENTS ON HISTORY AND FINDINGS:**

  
  

APPLICANTS NAME:			DISQUALIFYING DEFECTS:		
	Has been issued				
	Not issued, further evaluation required				
	Has been denied, letter of denial issued (Copy Attached)				

**MEDICAL EXAMINER'S DECLARATION:** I hereby certify that I personally examined the applicant named on this medical examination report, and that this report and any attachment embodies my findings completely and correctly.

EXAMINATION DATE	MEDICAL EXAMINER'S NAME AND ADDRESS	MEDICAL EXAMINER'S SIGNATURE