HISTORY FORM

*(Note: This form is to be filled out by the parent **prior** to the exam.)*

Name_____Date of birth _____

Sex_____Age_____Grade_____Sport(s) _____

Medicines and Allergies:
Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

_____

Do you have any allergies? ☐ No ☐ Yes If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects Other_____

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			19. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify: _____			20. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			22. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
4. Have you ever had surgery?			22. Do you have groin pain or a painful bulge or hernia?		
HEART HEALTH QUESTIONS	**Yes**	**No**	23. Have you ever had a head injury or concussion?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			24. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			25. Do you have headaches with exercise?		
7. Does your heart ever race or skip beats during exercise?			26. Do you have a history of seizure disorder?		
8. Has a doctor ever told you that you have any heart problems? If so, _____			27. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			28. Have you ever become ill while exercising in the heat?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			29. Do you get frequent muscle cramps when exercising?		
11. Have you ever had an unexplained seizure?			30.. Do you or someone in your family have sickle cell trait or disease?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			31. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	**Yes**	**No**	32. Have you had any eye injuries?		
13. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			33. Do you wear glasses or contact lenses?		
14. Have you ever had any broken or fractured bones or dislocated joints?			34. Do you worry about your weight?		
15. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			35. Are you on a special diet or do you avoid certain types of foods?		
16. Do you regularly use a brace, orthotics, or other device?			36. Have you ever had an eating disorder?		
17. Do you have a bone, muscle, or joint injury that bothers you?			**FEMALES ONLY**		
18. Do you have any history of juvenile arthritis or connective tissue disease?			37. Have you ever had a menstrual period? At what age was your first menstrual period?_____ When was your last menstrual period?_____		

Explain "yes" answers here:

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete_____Signature of parent/guardian_____Date _____

PHYSICAL EXAMINATION FORM

Name_____Date of birth _____

EXAMINATION				
Height	Weight			□ Male □ Female
BP	Pulse	Vision R 20/	L 20/	Corrected □ Y □ N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional/duck-walk, single leg hop		

□ Cleared for all sports without restriction

□ Not cleared

- □ Pending further evaluation
- □ For any sports
- □ For certain sports _____ Reason:_____

Recommendations:_____

I have examined the above-named student and completed physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Physician (print/type)_____Date:_____

Signature of physican_____Phone:_____