



SPORTS QUALIFYING PHYSICAL HISTORY FORM

DATE OF EXAM _____

Student Name: _____ Birth Date: _____ Age: _____ Gender: M / F

Address: _____

Home Telephone: _____ - _____ - _____

School: _____ Grade: _____ Sports: _____

History

Circle Y for Yes or N for No

Circle Question Number (1, etc) of questions for which the answer is unknown.

1. Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports? Y / N
2. Do you have an ongoing medical condition (like diabetes or asthma)? Y / N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Y / N
- List: _____
4. Do you have allergies to medicines, pollens, foods, or stinging insects? Y / N
5. Have you ever passed out or nearly passed out DURING exercise? Y / N
6. Have you ever passed out or nearly passed out AFTER exercise? Y / N
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Y / N
8. Does your heart race or skip beats during exercise? Y / N
9. Has a doctor ever told you that you have? (circle): High blood pressure A heart murmur High cholesterol A heart infection Rheumatic fever
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram, stress test) Y / N
11. Has anyone in your family died suddenly and unexpectedly for no apparent reason? Y / N
12. Does anyone in your family have a heart problem? Y / N
13. Has any family member or relative died of heart problems or of sudden death before age 50? Y / N
14. Has anyone in your family less than 50 years old had unexplained drowning while swimming or an unexplained car accident? Y / N
15. Does anyone in your family have Marfan syndrome? Y / N
16. Have you ever spent the night in a hospital? Y / N
17. Have you ever had surgery? Y / N
18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? Y / N
19. Have you had any broken or fractured bones, or dislocated joints? Y / N
20. Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? Y / N
- If Yes in Questions 18, 19 or 20, please circle the area below:
Head Neck Shoulder Chest Upper Arm Elbow Forearm Hand/Fingers Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes
21. Have you ever had a stress fracture? Y / N
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Y / N
23. Do you regularly use a brace or assistive device? Y / N
24. Has a doctor ever told you that you have asthma or allergies? Y / N
25. Do you cough, wheeze, chest tightness, or have difficulty breathing during or after exercise? Y / N
26. Is there anyone in your family who has asthma? Y / N
27. Have you ever used an inhaler or taken asthma medicine? Y / N
28. Do you develop a rash or hives when you exercise? Y / N
29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Y / N
30. Have you had infectious mononucleosis (mono) within the last month? Y / N
31. Do you have any rashes, pressure sores, or other skin problems? Y / N
32. Have you had a herpes skin infection? Y / N
33. Have you ever had a head injury or concussion? Y / N
34. Have you been hit in the head and been confused or lost your memory? Y / N
35. Have you ever had a seizure? Y / N
36. Do you have headaches with exercise? Y / N
37. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Y / N
38. Have you ever been unable to move your arms or legs after being hit or falling? Y / N
39. When exercising in the heat, do you have severe muscle cramps or become ill? Y / N
40. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Y / N
41. Have you had any problems with your eyes or vision? Y / N
42. Do you wear glasses or contact lenses? Y / N
43. Do you wear protective eyewear, such as goggles or a face shield? Y / N
44. Are you happy with your weight? Y / N
45. Are you trying to gain or lose weight? Y / N
46. Has anyone recommended you change your weight or eating habits? Y / N
47. Do you limit or carefully control what you eat? Y / N
48. Do you get tired more quickly than your friends do during exercise? Y / N
49. Do you have any concerns that you would like to discuss with a doctor? Y / N
- FEMALES ONLY**
50. Have you ever had a menstrual period? Y / N
51. How old were you when you had your first menstrual period? _____
52. How many menstrual periods have you had in the last year? _____

Notes: _____

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities.

Parent or Legal Guardian Signature _____

Student-Athlete Signature _____

Date _____

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name _____ Birth Date _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____, _____ / _____, _____ / _____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

Follow-Up Questions on More Sensitive Issues (Optional)

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: _____

MEDICAL	Normal	Abnormal findings	Initials*
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

Notes: _____

Clearance

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: _____

Not cleared for: All Sports Certain sports: _____ Reason: _____

Recommendations: _____

Emergency Information:

Allergies: _____

Other Information: _____

Name of Physician: (print/type/stamp) _____ (M.D., D.O., D.C.) Date: _____

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Address: _____ Phone: _____

Signature of Physician: _____