Athletic Physical Questionnaire

Student Name: _____

Health History - Please answer the following in the check box provided and give to your health provider or examining physician. Explain "yes" answers in the box below.

1. Have you ever been hospitalized (overnight)? [ ] Yes [ ] No

2. Have you ever had surgery? [ ] Yes [ ] No

3. Are you currently taking medication? [ ] Yes [ ] No

4. Do you have any allergies (medicines, pollen, bees)? [ ] Yes [ ] No

5. Have you ever passed out during exercise? [ ] Yes [ ] No

6. Have you ever been dizzy during exercise? (not from heat) [ ] Yes [ ] No

7. Have you ever had chest pain? [ ] Yes [ ] No

8. Do you tire more quickly than your friends during exercise? [ ] Yes [ ] No

9. Have you ever had high blood pressure? [ ] Yes [ ] No

10. Have you ever been told you had a heart murmur? [ ] Yes [ ] No

11. Have you ever had racing of your heart or skipped beats? [ ] Yes [ ] No

12. Has anyone in your family died of heart problems/sudden death before 40? [ ] Yes [ ] No

13. Does anyone in your family have Marfan's Syndrome? [ ] Yes [ ] No

14. Do you have any skin problems (itching, rashes, breaking out)? [ ] Yes [ ] No

15. Have you ever had a head injury? [ ] Yes [ ] No

16. Have you ever been knocked out, had a seizure, or had a burner/stinger? [ ] Yes [ ] No

17. Have you ever had heat cramps or been dizzy or passed out in the heat? [ ] Yes [ ] No

18. Do you use special pads or orthotic braces? [ ] Yes [ ] No

19. Have you ever injured (broken/fractured, sprained, dislocated, stress fractured)...?

[ ] Hand / fingers [ ] Shoulder [ ] Hip [ ] Shin / calf [ ] Wrist / forearm [ ] Neck [ ] Thigh
[ ] Ankle [ ] Elbow [ ] Chest/ribs [ ] Knee [ ] Foot / toes [ ] Upper arm [ ] Back

20. Have you ever had...?

[ ] Mononucleosis [ ] Diabetes [ ] Hepatitis [ ] Headaches (frequent) [ ] Eye/ear injuries
[ ] Tuberculosis [ ] Measles [ ] Hernia(s) [ ] Asthma [ ] Ulcers
[ ] Sickle cell trait/disease

21. When was your last tetanus shot? _____

22. About your weight: Do you think you are . . . [ ] just right? [ ] too heavy? [ ] too thin / light?

23. For females: Are your periods [ ] Regular/monthly? [ ] Irregular / skip months?
When was your first period and how old were you? _____ When was your last period? _____

Please ask the doctor to address any questions that you may have. All discussions are kept confidential.
Please explain <u>yes</u> answers on next page.

Student Name: _____

Please explain any "YES" from the previous page answers here:

Physical Examination

(To be completed by Medical Personnel)

Examination		
Height: Weight: BP: / (/)		
☐ Male ☐ Female Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
Medical	**Normal**	**Abnormal Findings**
Appearance *(Marfan stigmata [kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency])*		
Ears/eyes/nose/throat *(Pupils equal, hearing)*		
Lymph nodes		
Heart* *(Murmurs [auscultation standing, supine, +/- Valsalva], location of point of maximal impulse [PMI])*		
Pulses *(Simultaneous femoral and radial pulses)*		
Lungs		
Abdomen		
Genitourinary** *(males only)*		
Skin *(HSV, lesions suggestive of MRSA, tinea corporis)*		
Neurologic***		
Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional *(Duck-walk, single leg hop)*		

* Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam

**Consider GU exam if in private setting. Having third party recommended

***Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion

Annual Athletic Physical Exam – to be filled out by Doctor (page 2 of 2)

Student Name: _____

Student is planning on participating in the following sports (check all that apply):

[ ] girls volleyball	[ ] girls soccer	[ ] girls tennis	[ ] girls basketball	[ ] cross-country (co-ed)
[ ] boys volleyball	[ ] boys soccer	[ ] boys tennis	[ ] boys basketball	[ ] track (co-ed)

MEDICAL CLEARANCE

(As appropriate for age and development)

[ ] Full contact level (full, unrestricted participation)

[ ] Non contact: strenuous

[ ] Non contact: non-strenuous

[ ] Clearance deferred or no participation at this time because:

[ ] Needs clearance by specialist: _____

[ ] Needs to complete rehabilitation for current condition(s) prior to participation

Additional comments, allergy information, or emergency information:_____

_____

_____

_____

_____

_____

Physician's Statement:

(Student's name) _____ was examined by me on _____(date) and found physically fit to engage in high school athletics *as indicated 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). Results are to encourage, but in no way guarantee, the fitness and safety of this athlete.

Practitioner signature: _____ Date: _____

M.D. / D.O. / N.P. / P.A. / D.C.

Do not sign without student's name filled in

Physician's Office Stamp HERE (REQUIRED)