MEDICAL HISTORY

Student's Name: _____ **Age:** _____ **School:** _____

***** PARENTS/GUARDIANS: Please assure all questions are answered to the best of your knowledge. Not disclosing accurate information may put your child at risk during sports activity.**

GENERAL MEDICAL HISTORY	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below (check all that apply) ___ Anemia ___ Diabetes ___ Asthma ___ Infections Other:		
3. Have you ever spent the night in a hospital?		
4. Have you ever had surgery?		
HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Do you or someone in your family have sickle cell trait or disease? Who?		
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
8. Does your heart ever race or skip beats (irregular beats) during exercise?		
9. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ___ High blood pressure ___ A heart murmur ___ High cholesterol ___ A heart infection ___ Kawasaki disease Other:		
10. Has a doctor ever ordered a test for your heart? (EcgyEkg, echocardiogram, etc.)		
11. Do you get lightheaded or feel more short of breath than expected during exercise?		
12. Have you ever had an unexplained seizure?		
13. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
14. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
15. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
19. Have you ever had any broken, fractured or dislocated joints?		
20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
21. Have you ever had a stress fracture?		
22. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
23. Do you regularly use a brace, orthotics, or other assistive device?		
24. Do you have a bone, muscle, or joint that bothers you?		
25. Do any joints become painful, swollen, warm, or red?		
26. Do you have any history of arthritis or tissue disease?		

MEDICAL QUESTIONS	Yes	No
27. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
28. Have you ever used an inhaler or taken asthma medicine?		
29. Is there anyone in your family who has asthma?		
30. Were you without or are you missing a kidney, eye, testicle, spleen, or any other organ?		
31. Do you have groin pain or a painful bulge or hernia in the groin area?		
32. Have you had infectious mononucleosis in the last month?		
33. Do you have any rashes, sores, or other skin problems?		
34. Have you had a herpes or MRSA skin infection?		
35. Do you have a history of seizure disorders?		
36. Have you ever had a head injury or concussion? If yes, how many have you had? (list dates) _____		
37. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
38. Do you have headaches with exercise?		
39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
40. Have you ever been unable to move your arms or legs after being hit or falling?		
41. Have you ever become ill while exercising or the heat?		
42. Do you get frequent muscle cramps when exercising?		
43. Have you had any problems with your eyes or vision?		
44. Have you had an eye injury?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain food?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns you'd to discuss with the doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first period?		
54. How many periods have you had in the last month?		

Explain "Yes" answers:

_____

_____

_____

_____

***** PARENTS SIGN LAST PAGE BOLD BOX *****

Student's Name: _____ **Date of Birth:** _____ **Sport(s):** _____

Height _____ **Weight** _____ **Vision R/20**____ **L 20/**____ **Corrected:** ☐Y ☐N

Pulse _____ **BP (R arm) seated** _____/_____ **BP Re-Check (R arm) seated** _____/_____

☒ This section to be completed by Physician

Medical	Normal	Abnormal Findings
Appearance ▪ Marfan Stimata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat ▪ Pupils equal ▪ Hearing		
Lymph Nodes		
Heart[a] ▪ Murmurs (auscultation standing, supine, +/- Valsalva ▪ Location of point of maximal impulse (PMI)		
Pulses ▪ Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin ▪ HSV, lesions suggestive of MRSA, tinea corporis, etc		
Neurologic[c]		
Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Movement		

[a] Consider ECG, echo, and referral to cardiology for abnormal cardiac history or exam. [b] Consider GU exam in private setting with third party. [c] Consider cognitive evaluation or baseline if significant concussion history.

☐ **Cleared for all sports without restriction**

☐ **Cleared for all sports without restriction with recommendations for further evaluation or treatment**

for _____

☐ **NOT cleared → →** ☐ **Pending further evaluation** ☐ **For any sports** ☐ **For certain sports**

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) outlined above. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are explained to the student (and parents/guardians) and parents/guardians have had the opportunity to ask questions.

Name of Physician (print/type) _____ **Date**_____

Address _____ **Phone** _____

Signature of physician _____, **MD / DO / NP / PA**

I have reviewed and answered each question on the previous page, and assure that all responses are accurate.

Signature of Student: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

MEDICAL HISTORY

Student's Name: _____ **Age:** _____ **School:** _____

*** **PARENTS/GUARDIANS: Please assure all questions are answered to the best of your knowledge. Not disclosing accurate information may put your child at risk during sports activity.**

GENERAL MEDICAL HISTORY	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below (check all that apply): ___ Anemia ___ Diabetes ___ Asthma ___ Infections ___ Other		
3. Have you ever spent the night in a hospital?		
4. Have you ever had surgery?		
HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Do you or someone in your family have sickle cell trait or disease? Who?		
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
8. Does your heart ever race or skip beats (irregular beats) during exercise?		
9. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ___ High blood pressure ___ A heart murmur ___ High cholesterol ___ A heart infection ___ Kawasaki disease ___ Other:		
10. Has a doctor ever ordered a test for your heart? (Ecg/Ekg, echocardiogram, etc.)		
11. Do you get lightheaded or feel more short of breath than expected during exercise?		
12. Have you ever had an unexplained seizure?		
13. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
14. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
15. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
19. Have you ever had any broken, fractured or dislocated joints?		
20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
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23. Do you regularly use a brace, orthotics, or other assistive device?		
24. Do you have a bone, muscle, or joint that bothers you?		
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MEDICAL QUESTIONS	Yes	No
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29. Is there anyone in your family who has asthma?		
30. Were you without or are you missing a kidney, eye, testicle, spleen, or any other organ?		
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34. Have you had a herpes or MRSA skin infection?		
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40. Have you ever been unable to move your arms or legs after being hit or falling?		
41. Have you ever become ill while exercising in the heat?		
42. Do you get frequent muscle cramps when exercising?		
43. Have you had any problems with your eyes or vision?		
44. Have you had an eye injury?		
45. Do you wear glasses or contact lenses?		
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50. Have you ever had an eating disorder?		
51. Do you have any concerns you'd to discuss with the doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first period?		
54. How many periods have you had in the last month?		

Explain "Yes" answers:

_____

_____

_____

_____

*** PARENTS SIGN LAST PAGE BOLD BOX ***

Student's Name: _____ **Date of Birth:** _____ **Sport(s):** _____

Height _____ **Weight** _____ **Vision** R/20 ____ L 20/____ **Corrected:** ☐Y ☐N

Pulse _____ **BP (R arm) seated** _____/_____ **BP Re-Check (R arm) seated** _____/_____

This section to be completed by Physician

Medical	Normal	Abnormal Findings
Appearance • Marfan Stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/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, etc.		
Neurologic		
Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Movement		

* Consider ECG, echo, and referral to cardiology for abnormal cardiac history or exam. * Consider GU exam in private setting with third party. * Consider cognitive evaluation or baseline if significant concussion history.

☐ **Cleared for all sports without restriction**

☐ **Cleared for all sports without restriction with recommendations for further evaluation or treatment for** _____

☐ **NOT cleared → →** ☐ **Pending further evaluation** ☐ **For any sports** ☐ **For certain sports**

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) outlined above. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are explained to the student (and parents/guardians) and parents/guardians have had the opportunity to ask questions.

Name of Physician (print/type) _____ **Date** _____

Address _____ **Phone** _____

Signature of physician _____, **MD / DO / NP / PA**

I have reviewed and answered each question on the previous page, and assure that all responses are accurate.

Signature of Student: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____