Athlete's Name ______________________________

MEDICAL HISTORY **Instructions: Circle the number next to any questions that are yes. Explain your "yes" answers in space provided at the bottom.**

Past Medical History

1. Have you had a medical illness (other than cold or flu) since your last sports physical?
2. Have you had a serious injury (sports related or not) since your last sports physical?
3. Do you have any ongoing or chronic illnesses?
4. Have ever had any major surgery (other than tonsillectomy, adenoidectomy, or tooth extraction)?
5. Are you aware of any missing paired organs (i.e. Eye, kidney, lung, or male/female genitalia)?

Medications, Supplements, and Allergies

6. Are you currently taking any prescription medications?
7. Has a doctor ever prescribed a mouth or nose inhaler?
8. Are you currently taking any non-prescription or "over-the-counter" medications?
9. Have you ever taken (or are you currently taking) any supplements to improve your performance?
10. Have you ever taken (or are you currently taking) supplements to lose or gain weight?
11. Do you have any allergies to medication?
12. Do you have environmental allergies (i.e. Molds, pollens, grass, or insects etc.)?
13. Have you every developed hives or skin rash during or after exercise?

Cardiovascular

14. Have you ever passed out during or after exercise?
15. Have you ever been "dizzy" during or after exercise?
16. Have you ever had chest pain during or after exercise?
17. Do you get tired more quickly than your friends do during exercise?
18. Have you ever had racing of your heart?
19. Have you ever had your heart skip a beat during or after exercise?
20. Has anyone ever told you that you have high blood pressure?
21. Have you ever been told you have a heart murmur?
22. Has anyone in your family died suddenly before the age of 50?
23. Have you recently had an infection with a fever?
24. Has a doctor ever denied or restricted your participation in sports for any heart problems?

Skin Problems

25. Do you currently have any open, bleeding, oozing skin lesions or sores?
26. Are you currently being treated for any skin disorders [acne, warts, infection, itching, rash, skin color change, or blisters]?

Neurological

27. Have you ever had a concussion or head injury?
28. Have you ever been "knocked-out", been unconscious, or lost your memory?
29. Have you ever had a seizure?
30. Do you have frequent or severe headaches made worse by exercise?
31. Have you ever had numbness or tingling in your arms, hands, legs or feet?
32. Have you ever experienced a "stinger", "burner", or pinched nerve?

Heat Exposure

33. Have you ever become ill during or after exercising in the heat?
34. Have you had recurrent heat related cramps?
35. Have you ever passed out in the heat?

Pulmonary

36. Do you cough, wheeze, or have trouble breathing during or after activity?
37. Do you have asthma?

Musculoskeletal

38. Do you use any protective or corrective braces (i.e. knee brace, ankle brace, back brace, or neck roll) for sports?
39. Have you had any sprains, strains or swelling after an injury?
40. Have you had any fractured or broken bones?
41. Have you had any dislocated joints?

Eyes and Vision

42. Have you had any problems with your eyes or vision?
43. Do you wear glasses, contacts, or protective eyewear?

Weight

44. Are you trying to lose weight?

Immunizations

45. Are your immunizations current?
46. Have you had a tetanus shot in the last 5 to 10 years?
47. Have you had chicken pox?

Females

48. Did your menstrual periods begin more than 3 years ago?
49. Do you have more, or less, than 10 menstrual periods in a year?
50. Do your menstrual periods ever go away or stop when you exercise?

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PHYSICAL EXAMINATION (Completion of a pre-participation physical examination is not intended to be a substitute for a full physical evaluation by your physician.)

Height: __________ Weight: __________ Pulse: __________ Blood Pressure: __________

Vision Corrected: ______________________ Pupils: Equal __________ Unequal__________

	Normal	Abnormal
Appearance		
Eyes, Ears, Nose, Throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia		
Skin		

	Normal	Abnormal
Neck		
Back		
Shoulder, Arm		
Elbow, Forearm		
Wrist, Hand		
Hip, Thigh		
Knee		
Leg, Ankle		
Foot		

CLEARANCE

- ❑ Cleared for all sports without restriction.
- ❑ Cleared after completing evaluation or rehabilitation for: ______________________
- ❑ Not Cleared for: Contact sports ________ Non-contact sports ________ Dynamic exercise ________ Static exercise ________

Specific sports: ______________________

Reason: ______________________

Recommendations: ______________________

Physician (Print): ______________________ Date: ______________

Signature: ______________________ Phone: ______________