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| --- | --- | --- |
|  | THE UNIVERSITY OF WEST ALABAMA | REVISED 07/15/18 |
| MEDICAL HISTORY & PRE-PARTICIPATION |  |
| ***PHYSICAL EXAMINATION FORM*** | DATE: |  | / |  | / |  |  |
| Athlete’s |  |  | Month |  | Day |  | Year |  |
| Name: |  | Sports(s): |  |
|  | (Last) (First) (Middle) (Nickname) |  |  |
| Social |  |  |  |
| Security No: |  | / |  | / |  |  |  | Date of Birth: |  | / |  | / |  |  |  | / |  | / |  |
|  |  |  |  |  |  |  |  | Month |  | Day |  | Year |  | Age |  | Sex |  | Race |
| Student No: |  |  |  | Classification: | Fr. So. Jr. Sr. Red Shirt Sr. |  |
|  | (Different than Social Security No.) |
|  |  |   | e-Mail Address(es): |  |
| Local Apartment, Address, Dormitory, etc. |  | Local Phone: |  | Cell Phone: |  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
| **I. Person to notify in case** **of an Emergency:** |  | Relationship: |  |
| Address: |   |
|  | (City) (State) (Zip)  |
| Home Phone:  | ( |  | ) |  | Business Phone: | ( |  | ) |  |
| Cell Phone | ( |  | ) |  | e-Mail: |  |

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| --- | --- |
| **II. Father’s Name:** |  |
| Address: |  |
|  |
| (City) (State) (Zip) |
| e-Mail: |  |
| Home Phone: | ( |  | ) |  |
| Business Phone: | ( |  | ) |  |
| Cell Phone | ( |  | ) |  |

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| --- | --- |
| **III. Mother’s Name:** |  |
| Address: |  |
|  |
| (City) (State) (Zip) |
| e-Mail: |  |
| Home Phone: | ( |  | ) |  |
| Business Phone: | ( |  | ) |  |
| Cell Phone | ( |  | ) |  |

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| **IV. Marital Status** **(if applicable)** | S | M | W | D | Separated |  | Spouse’sName: |  |
| Address: |  | e-Mail: |  |
|  | (City) (State) (Zip) |  |
| Home Phone: | ( |  | ) |  | Business Phone: | ( |  | ) |  | Cell Phone: | ( |  | ) |  |

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| --- | --- | --- | --- | --- | --- | --- |
|  **V. Name of family physicians:** |  | Business Phone | ( |  | ) |  |
| Address: |  |
|  | (City) (State) (Zip) |

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|  |
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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **VI. High School attended:** |  | School Phone: | ( |  | ) |  |
| Address: |   |
|  | (City) (State) (Zip)  |
| Coach’s Name:  |  | Athletic Trainer’s Name: |  |

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| **VII. Junior College(s) /** **College(s) previously attended:** |  | College Phone: | ( |  | ) |  |
| Address: |   |
|  | (City) (State) (Zip)  |
| Coach’s Name:  |  | Athletic Trainer’s Name: |  |

  |

**A. FAMILY MEDICAL HISTORY:** Has any blood relative ever had? **(CIRCLE THE CORRECT ANSWER)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Cancer | **YES** | **NO** | Stroke | **YES** | **NO** | Alcoholism/Drug Abuse/Dependency | **YES** | **NO** |
| Diabetes | **YES** | **NO** | Epilepsy/Seizures | **YES** | **NO** | Die suddenly before age 50 years | **YES** | **NO** |
| Heart Trouble/Disease | **YES** | **NO** | Mental Illness/Depression | **YES** | **NO** | Sickle Cell Trait/Disease | **YES** | **NO** |
| High Blood Pressure | **YES** | **NO** | Suicide | **YES** | **NO** | Bleeding Disorder/Blood Disease | **YES** | **NO** |
| Gout | **YES** | **NO** | Mental Disorders | **YES** | **NO** | Leukemia | **YES** | **NO** |
| Indicate which family member? |
| Other, please explain: | **Blood type:** A+ A- B+ B- AB+ AB- O+ O- |

**B. PERSONAL HEART/CARDIAC MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?
 | **YES** | **NO** |
| 1. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
 | **YES** | **NO** |
| 1. Have you ever passed out or nearly passed out during or after exercise?
 | **YES** | **NO** |
| 1. Have you had unexplained temporary loss of consciousness/near temporary loss of consciousness?
 | **YES** | **NO** |
| 1. Do you get more tired or short of breath more quickly than your friends during exercise?
 | **YES** | **NO** |
| 1. Do you get lightheaded or feel more short of breath than expected during exercise?
 | **YES** | **NO** |
| 1. Does your heart ever race or skip beats (irregular beats) during exercise?
 | **YES** | **NO** |
| 1. Have you ever had an unexplained seizure?
 | **YES** | **NO** |
| 1. Has a doctor ever told you that you have any heart problems? Check all that apply:
 | **YES** | **NO** |
| 1. Hypertension (High Blood Pressure)?
 | **YES** | **NO** | If yes, please list any medications taken for this condition: |  |
| 1. Hypotension (Low Blood Pressure)?
 | **YES** | **NO** | If yes, please list any medications taken for this condition: |  |
| 1. Heart Disease?
 | **YES** | **NO** | If yes, please list any medications taken for this condition: |  |
| 1. Heart Disorder?
 | **YES** | **NO** | If yes, please list any medications taken for this condition: |  |
| 1. Heart Murmur?
 | **YES** | **NO** | If yes, please list any medications taken for this condition: |  |
| 1. Heart Infection?
 | **YES** | **NO** | If yes, please list any medications taken for this condition: |  |
| 1. High Cholesterol?
 | **YES** | **NO** | If yes, please list any medications taken for this condition: |  |
| 1. Kawasaki Disease?
 | **YES** | **NO** | If yes, please list any medications taken for this condition: |  |
| 1. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | **YES** | **NO** | If yes, please list any medications taken for this condition: |  |
| 1. Has a doctor ever ordered a test for your heart? (EKG, echocardiogram, Treadmill Stress Test)
 | **YES** | **NO** |
| **FAMILY HEART/CARDIAC MEDICAL HISTORY** |
| 1. Has any family member or relative died of heart problems or had sudden and unexpected death before age 50? (including drowning, unexplained car accident, or sudden infant death syndrome)?
 | **YES** | **NO** |
| 1. Has any family member or relative had a disability from heart disease in a close relative age before age 50?
 | **YES** | **NO** |
| 1. Does anyone in your family have any of the following conditions? Indicate which family member:
 | **YES** | **NO** |
| 1. Hypertrophic cardiomyopathy
 | **YES** | **NO** | 1. Short QT syndrome
 | **YES** | **NO** | 1. Long QT syndrome
 | **YES** | **NO** |
| 1. Marfan syndrome
 | **YES** | **NO** | 1. Brugada syndrome
 | **YES** | **NO** | 1. Arrythmogenic cardiomyopathy
 | **YES** | **NO** |
| 1. Catecholaminergic polymorphic ventricular tachycardia
 | **YES** | **NO** |
| 1. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
 | **YES** | **NO** |
| 1. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?
 | **YES** | **NO** |

**C. GENERAL MEDICAL INFORMATION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Have you ever been to an eye doctor?
 | YES | **NO** | Date of last visit: |  |
| 1. Do you wear glasses now?
 | **YES** | **NO** | Physician name: |  |
| If yes: | Reading only |  | Distance only |  | All the time |  | **Rx:** | **Right** |  | **Left** |  |
| 1. Do you wear contact lenses?
 | **YES** | NO | 1. Is your color vision normal?
 | **YES** | **NO** |
| If yes: | Soft Lenses |  | Hard Lenses |  | **Rx:** | **Right** |  | **Left** |  |
| 1. Do you wear either to participate in sports?
 | **YES** | **NO** | 1. Have you ever worn a false eye?
 | **YES** | **NO** |
| 1. Have you ever had an eye injury and if yes, please give date and specify below:
 | **YES** | **NO** |
| 1. Do you have a vision defect in either one or both eyes and if yes, please specify below:
 | **YES** | **NO** |
| 1. Have you ever had glaucoma?
 | **YES** | **NO** | Have you ever had retinal detachment? | **YES** | **NO** |
| 1. Do you have a hearing defect? If yes, please specify below and list any hearing aids worn:
 | **YES** | **NO** |
| 1. Have you ever fractured a tooth?
 | **YES** | **NO** |
| 1. Have you ever had a tooth knocked out?
 | **YES** | **NO** |
| 1. Do you have any severe tooth trouble, gum trouble, or dead teeth? If yes, please list details below:
 | **YES** | **NO** |
| 1. Do you wear any dental appliances?
 | **YES** | **NO** | If so, do you wear them during practice? | **YES** | **NO** |
| 1. If yes, circle the appropriate appliance: Corrective Braces. Permanent Bridge, Permanent Crown or Jacket, Removable Partial or Full Plate
 |
| 1. In the past 12 months have you been treated for >>
 | Mononucleosis? | YES | NO | Pneumonia? | YES | NO | Infectious Virus? | **YES** | **NO** |
| 1. Do you currently take any medicines or drugs? If yes, what medications or drugs are you taking, and for what reason?
 | **YES** | **NO** |
| 1. Have you ever had an internal injury? If yes, describe the nature of the injury and the body part(s) or organ(s) involved?
 | **YES** | **NO** |
| 1. Were you born with a complete and functional set of paired organs? (Eyes, Ears, kidneys, Ovaries/ Testicles, Lungs):
 | **YES** | **NO** |
| 1. If not, which organs were involved?
 |
| 1. Have you ever lost the full use of the following organs, either temporarily or permanently? (Hearing, Sight, Kidneys, Lungs, Testicles(male), Ovaries(female), other) If yes, please list the organ(s) and details regarding the loss, including the dates and treating physicians for each:
 | **YES** | **NO** |
| 1. Have you ever had surgery to repair or remove any organ? (Hernia, Tonsils, Appendix, Spleen, etc.): If yes, please list the organ(s) and details regarding the repair and/or removal including the dates and treating physicians for each:
 | **YES** | **NO** |
| 1. Are you an Epileptic or ever have had an Epileptic seizure ? if yes, please list any and all medications for this condition:
 | **YES** | **NO** |
| 1. Do you have a Hernia? If yes, where?
 | **YES** | **NO** |
| 1. Have you had either a gain or loss of greater than ten (10) pounds in the past 12 months?
 | **YES** | **NO** |
| 1. Do you currently have any body piercing(s)?
 | **YES** | **NO** | If so, where? | 1. Do you have a tattoo?
 | **YES** | **NO** |

**D. CONCUSSION/HEAD INJURY HISTORY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| A concussion is a disturbance in brain function caused by a direct or indirect force to the head. It results in a variety of nonspecific symptoms (like those listed below) and often does not involve loss of consciousness. Concussion should be suspected in the presence of any one or more of the following:

|  |  |
| --- | --- |
| * Symptoms (such as headache), or
 | * Impaired brain function (e.g. confusion) or
 |
| * Physical signs (such as unsteadiness), or
 | * Abnormal behavior
 |

Playing with a concussion can result in significant long and short term adverse side effects.  It is of extreme importance to know your individual concussion/head injury history!1. Have you ever had a Concussion?
 | **YES** | **NO** |
| 1. If yes, please list the number of times, dates and severity of each here:
 |
| 1. Have you ever been removed from practice or games to be evaluated for a concussion?
 | **YES** | **NO** |
| 1. Have you ever been knocked out or lose consciousness due to head or body contact?
 | **YES** | **NO** |
| 1. If yes, please list the number of times, dates and severity of each here:
 |
| 1. Did you have amnesia with a concussion?
 | **YES** | **NO** |
| 1. How long were you held from practice or play with a concussion and how much practice or game time did you miss?
 |
| 1. Was the concussion sports related?
 | **YES** | **NO** | **Practice?** | **Game?** |
| 1. Did you see a physician for any of the above questions?
 | **YES** | **NO** |
| 1. If yes, please list the approximate dates, doctor(s)’ names, address, phone:
 |
| 1. Did you have a CT (Cat Scan) or MRI?
 | **YES** | **NO** |
| 1. Did you see a neurologist?
 | **YES** | **NO** |
| 1. Did or do you have long term academic side effects?
 | **YES** | **NO** |
| 1. Did or do you have frequent or recurrent headaches after the concussion?
 | **YES** | **NO** |
| 1. Have you ever been told you have migraine headaches?
 | **YES** | **NO** |
| 1. If yes, please list the medications, doctor(s)’ names, address, phone:
 |
| 1. Have you ever been hospitalized for any of the concussions you sustained?
 | **YES** | **NO** |
| 1. Do you have difficulty with your eyes during or after competition?
 | **YES** | **NO** |
| 1. Have you ever had a Skull Fracture?
 | **YES** | **NO** | Double Vision? | **YES** | **NO** | Blurred Vision? | **YES** | **NO** |
| 1. If yes, please explain:
 |
| 1. Have you ever had a seizure?
 | **YES** | **NO** |
| 1. Did you see a physician for any of the above problems?
 | **YES** | **NO** |
| 1. If yes, please list the approximate dates, doctor(s)’ names, address, phone:
 |

**E. MENTAL HEALTH HISTORY**

|  |  |  |
| --- | --- | --- |
| 1. I often have trouble sleeping.
 | **YES** | **NO** |
| 1. I wish I had more energy most days of the week.
 | **YES** | **NO** |
| 1. I think about things over and over.
 | **YES** | **NO** |
| 1. I feel anxious and nervous much of the time.
 | **YES** | **NO** |
| 1. I often feel sad or depressed.
 | **YES** | **NO** |
| 1. I struggle with being confident.
 | **YES** | **NO** |
| 1. I don’t feel hopeful about the future.
 | **YES** | **NO** |
| 1. I have a hard time managing my emotions (frustration, anger, impatience)
 | **YES** | **NO** |
| 1. I have feelings of hurting myself or others.
 | **YES** | **NO** |
| 1. Do you make yourself sick because you feel uncomfortably full?
 | **YES** | **NO** |
| 1. Do you worry that you have lost control over how much you eat?
 | **YES** | **NO** |
| 1. Have you recently lost more than 15 pounds in a three-month period?
 | **YES** | **NO** |
| 1. Do you believe yourself to be fat when others say you are thin?
 | **YES** | **NO** |
| 1. Would you say food dominates your life?
 | **YES** | **NO** |

**F. HEAT ILLNESS HISTORY**

|  |  |  |
| --- | --- | --- |
| 1. Have you ever previously been diagnosed with exertional heat stroke?
 | **YES** | **NO** |
| 1. If yes, how long ago?
 |
| 1. Have you had any complications since then?
 | **YES** | **NO** |
| 1. How long did it take you to return to full participation?
 |
| 1. Did you have any complications upon your return to play?
 | **YES** | **NO** |
| 1. Was an exercise heat tolerance test conducted to assess your thermoregulatory capacity?
 | **YES** | **NO** |
| 1. Have you ever been diagnosed with heat exhaustion? If yes
 | **YES** | **NO** |
| 1. When?
 |  | 1. How many times?
 |
| 1. Have you ever had trouble or complications from exercising in the heat (eg, feeling sick, throwing up, dizzy, lack of energy, decreased performance, muscle cramps)?
 | **YES** | **NO** |
| 1. Have you ever had a heat illness requiring hospitalization?
 | **YES** | **NO** |
| 1. How much training have you been doing recently (in the past 2 weeks)?
 |
| 1. Has this been performed in warm or humid weather?
 | **YES** | **NO** |
| 1. Have you been training during the last 2 months?
 | **YES** | **NO** |
| 1. Would you say you are in poor, good, or excellent condition?
 | **YES** | **NO** |
| 1. Have you ever had trouble with dehydration? (Excess loss of salt & water)
 | **YES** | **NO** |
| 1. Describe your drinking habits.
 |
| 1. Are you conscious of how much you consume?
 | **YES** | **NO** |
| 1. Is your urine consistently dark?
 | **YES** | **NO** |
| 1. Would you consider yourself a heavy or a salty sweater?
 | **YES** | **NO** |
| 1. How many hours of sleep do you get per night?
 |
| 1. Do you sleep in an air-conditioned room?
 | **YES** | **NO** |
| 1. Do you take any supplements or ergogenic aids?
 | **YES** | **NO** |

**G. GENERAL MEDICAL ALLERGIES: Please answer as to whether you are allergic to the following items?**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Aspirin | **YES** | **NO** | Penicillin | YES | **NO** | Tetanus antitoxin or serums | **YES** | **NO** | Bee stings | **YES** | **NO** |
| Codeine | **YES** | **NO** | Erythromycin | **YES** | **NO** | Novocaine or other anesthetics | **YES** | **NO** | Fire ant bits | **YES** | **NO** |
| Cortisone | **YES** | **NO** | Ibuprofen | **YES** | **NO** | Hay Fever – dust/mold/pollen/grass | **YES** | **NO** | Wasps stings | **YES** | **NO** |
| Sulfa Drugs | **YES** | **NO** | Acetaminophen | **YES** | **NO** | Oral Anti-Inflammatories | **YES** | **NO** | Latex | **YES** | **NO** |
| Iodine | **YES** | **NO** | Peanuts | **YES** | **NO** | Nail Polish or Cosmetics | **YES** | **NO** | Shellfish | **YES** | **NO** |
| 1. Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here:
 | **YES** | **NO** |
|  |
| 1. Have you ever had any reaction to Serum Drugs? If yes, please list the drugs and related details here:
 | **YES** | **NO** |
|  |

**H. ASTHMA/DIABETIS/SICKLE-CELL HISTORY**

|  |  |  |
| --- | --- | --- |
| 1. Have you ever suffered from or been diagnosed with Exercise Induced Asthma (EAI)? If yes, what medication(s) are you taking to control EIA?
 | **YES** | **NO** |
| 1. Are you a Diabetic or ever been treated for Diabetes? If yes, please list the age at which your diabetes began as well as any and all medications you take for this condition:
 | **YES** | **NO** |
| 1. Do you know your sickle cell trait status?
 | **YES** | **NO** |
| 1. Does anyone in your family have sickle cell disease or trait?
 | **YES** | **NO** |
| 1. Have you ever been diagnosed with either Sickle-cell anemia or trait?
 | **YES** | **NO** |

**I. MEDICAL ILLNESS HISTORY: \*NOTE: This information will be kept CONFIDENTIAL!!!**

1. Have you **EVER HAD** or do you **NOW** have any of the conditions below? If so, check yes. If not, check no.

2. If yes, put your age the condition occurred at in the appropriate box.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CHECK EACH ITEM** | **AGE** | **YES** | **NO** | **CHECK EACH ITEM** | **AGE** | **YES** | **NO** | **CHECK EACH ITEM** | **AGE** | **YES** | **NO** |
| Any Heart Disease |  |  |  | Visual Changes |  |  |  | Rectal Bleeding |  |  |  |
| Palpitation/ Pounding Heart |  |  |  | Ear Infections |  |  |  | Any ruptured organs |  |  |  |
| Pain/Pressure in Chest |  |  |  | Hearing Defect/Loss |  |  |  | Appendicitis |  |  |  |
| Pericarditis |  |  |  | Nasal Polyps |  |  |  | Gout |  |  |  |
| Shortness of Breath |  |  |  | Ringing in Ears |  |  |  | Seizures/ Convulsions/ Fits |  |  |  |
| Rheumatic Heart Disease |  |  |  | Recurrent Sinusitis |  |  |  | Eating Disorder |  |  |  |
| Abnormal Bleeding |  |  |  | Sinus Infections |  |  |  | Hernia |  |  |  |
| Abnormal Bruising |  |  |  | Herpes Virus (Oral) |  |  |  | Kidney Injury |  |  |  |
| Anemia |  |  |  | Sore Throat |  |  |  | Kidney Stones |  |  |  |
| Blood Clots |  |  |  | Recurring Coughing |  |  |  | Kidney Trouble/ Disease |  |  |  |
| Blood Disease |  |  |  | Bronchitis |  |  |  | Bloody Urine |  |  |  |
| Contact with AIDS or HIV |  |  |  | Asthma |  |  |  | Frequent Urination |  |  |  |
| Diabetes |  |  |  | Exercise Induced Asthma |  |  |  | Painful Urination |  |  |  |
| Lyme Disease |  |  |  | Pleurisy |  |  |  | Sugar in Urine |  |  |  |
| Chicken Pox |  |  |  | Pneumonia |  |  |  | Urinary Tract Infection |  |  |  |
| Diphtheria |  |  |  | Car or Air Sickness |  |  |  | Herpes Virus (Genital) |  |  |  |
| Measles-German (3 day) (Rubella) |  |  |  | Frequent Respiratory Infections |  |  |  | Sexually Transmitted Venereal Disease |  |  |  |
| Measles-Red (10 day) (Rubeola) |  |  |  | Contact with Hepatitis B (HBV) |  |  |  | Muscular Disease |  |  |  |
| Measles-Baby (Roseala) |  |  |  | Gall Bladder Trouble |  |  |  | Muscle Cramps |  |  |  |
| Malaria |  |  |  | Gallstones  |  |  |  | Birth Defects |  |  |  |
| Mumps |  |  |  | Goiter/Thyroid Disease |  |  |  | Neuritis |  |  |  |
| Polio |  |  |  | Mononucleosis |  |  |  | Skin Trouble or Disease |  |  |  |
| Rheumatic Fever |  |  |  | Jaundice |  |  |  | Amnesia |  |  |  |
| Scarlet Fever |  |  |  | Liver Trouble |  |  |  | Depression |  |  |  |
| Small Pox |  |  |  | Stomach (Peptic) Ulcer |  |  |  | Drug Dependency |  |  |  |
| Typhoid Fever |  |  |  | Abdominal Pain |  |  |  | Excessive Worry |  |  |  |
| Tuberculosis |  |  |  | Frequent Nausea |  |  |  | Fear of High Places |  |  |  |
| Whooping Cough |  |  |  | Frequent Vomiting |  |  |  | Insomnia |  |  |  |
| Cancer |  |  |  | Frequent Diarrhea |  |  |  | Mental Disorder |  |  |  |
| Tumor/ Growth/ Cyst |  |  |  | Constipation |  |  |  | Nervous Trouble |  |  |  |
| Meningitis |  |  |  | Intestinal Trouble |  |  |  | Psychiatric Problems |  |  |  |
| Frequent Headaches |  |  |  | Gastrointestinal Bleeding |  |  |  | Unusual Fatigue |  |  |  |
| Migraine Headaches |  |  |  | Hemorrhoids |  |  |  |  |  |  |  |

**I. IMMUNIZATION RECORD:**

|  |  |  |  |
| --- | --- | --- | --- |
| **CONDITION** | **YES** | **NO** | **DATE OF INJECTION(S)** |
| Tetanus/Diphtheria |  |  |  |
| Measles, Mumps and Rubella (MMR) |  |  | 1. | 2. |
| Measles and Rubella (MR) |  |  | 1. | 2. |
| Influenza |  |  |  |
| Hepatitis B |  |  | 1. | 2. | 3. |
| Meningitis Vaccine |  |  | A. | B. |

1. **NON-ATHLETIC SURGERY:**

|  |
| --- |
| If you have ever had any non-athletic surgeries; list them below: |
| DATES | **SURGICAL PROCEDURES** | **PHYSICIANS** | **COMPLICATIONS** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**K. NUTRITION, DRUGS, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS:**

Check the appropriate space according to your use of the following products:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **NEVER** | **RARELY** | **OCCASIONALLY** | **FREQUENTLY** |
| Stimulants (Benzedrine, Amphetamines, etc.) |  |  |  |  |
| Chewing Tobacco, Snuff, or Smokeless Tobacco |  |  |  |  |
| Cigarettes, Cigars, Pipe or Hookah |  |  |  |  |
| e-cigarettes or Vaping |  |  |  |  |
| Marijuana or Cannabis |  |  |  |  |
| Vitamins |  |  |  |  |
| Sleeping Pills |  |  |  |  |
| Diet Pills |  |  |  |  |
| Laxatives |  |  |  |  |
| Alcoholic Beverages |  |  |  |  |
| Anabolic Steroids (growth stimulants) |  |  |  |  |
| Androstenedione |  |  |  |  |
| Amino Acids |  |  |  |  |
| Creatine phosphate |  |  |  |  |
| Antihistamines |  |  |  |  |
| Ephedrine |  |  |  |  |
| Any other diet, nutritional or performance enhancing drug |  |  |  |  |

**L. EATING DISORDERS:**

|  |  |  |
| --- | --- | --- |
| 1. Have you ever had a problem with food bingeing? If yes, when?
 | **YES** | **NO** |
| 1. Has it ever been suggested or have you ever been diagnosed as being anorexic? If yes, when?
 | **YES** | **NO** |
| 1. Have you ever been diagnosed as bulimic or having bulimia? If yes, when?
 | **YES** | **NO** |
| 1. Do you sometimes or often induce vomiting after eating?
 | **YES** | NO |
| 1. Have you or do you take laxatives to prevent being overweight?
 | **YES** | **NO** |

**M. GYNECOLOGICAL HISTORY: \*\*\*ONLY FEMALES ANSWER THIS SECTION\*\*\***

**CHECK YES OR NO FOR THE FOLLOWING & IF THE ANSWER IS YES, WRITE IN THE AGE AT WHICH THE CONDITION OCCURRED.**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Number** | **Date** | **Age** |  | **Yes** | **No** | **Age** |  | **Yes** | **No** | **Age** |
| Number of Pregnancies |  |  |  | Scanty Flow |  |  |  | Absence of Menstruation |  |  |  |
| Number of Births |  |  |  | Excessive Flow |  |  |  | Painful Menstruation |  |  |  |
| Abnormal Pap Smears |  |  |  | Vaginal Discharge |  |  |  | Menstrual Cramps |  |  |  |
| Last Pap Smear |  |  |  | Length of Cycle |  |  |  | Irregular Periods |  |  |  |
| Last Period |  |  |  | Period Duration |  |  |  | Lumps in Breast |  |  |  |
| Endometriosis |  |  |  | Age Periods Began  |  |  |  | Genital Itching |  |  |  |
| Are currently taking Birth Control Pills? | **YES** | **NO** | If yes, what type are you taking? |

**ORTHOPAEDIC MEDICAL HISTORY:**

**N. FRACTURES:**

|  |  |  |
| --- | --- | --- |
| 1. Have you ever broken (fractured) a bone? If yes, please fill in the appropriate boxes below:
 | **YES** | **NO** |
| **BODY PART** | DATES | **BODY PART** | **RIGHT** | **LEFT** | DATES |
| SKULL |  | COLLAR BONE |  |  |  |
| NOSE |  | UPPER ARM |  |  |  |
| FACE |  | FOREARM |  |  |  |
| JAW |  | WRIST |  |  |  |
| NECK |  | HAND |  |  |  |
| SPINE |  | THIGH |  |  |  |
| PELVIS |  | LOWER LEG |  |  |  |
| RIBS |  | FOOT |  |  |  |
| FINGERS | R\_\_\_\_\_\_ | 1\_\_\_\_\_, 2\_\_\_\_\_, 3\_\_\_\_\_, 4\_\_\_\_\_, 5\_\_\_\_\_ | L\_\_\_\_\_\_ | 1\_\_\_\_\_, 2\_\_\_\_\_, 3\_\_\_\_\_, 4\_\_\_\_\_, 5\_\_\_\_\_ |
| TOES | R\_\_\_\_\_\_ | 1\_\_\_\_\_, 2\_\_\_\_\_, 3\_\_\_\_\_, 4\_\_\_\_\_, 5\_\_\_\_\_ | L\_\_\_\_\_\_ | 1\_\_\_\_\_, 2\_\_\_\_\_, 3\_\_\_\_\_, 4\_\_\_\_\_, 5\_\_\_\_\_ |
| 1. Did the fracture require surgery or create any residual defect? If yes, please describe the defect or type of surgery, date, physician, and location of the hospital.
 | **YES** | **NO** |
| 1. Have you ever had a calcium deposit form in your thigh or anywhere else following a bad bruise?

 If yes, where is the calcium deposit located? | **YES** | **NO** |
| 1. Have you ever had a bone spur develop and if so, where?
 | **YES** | **NO** |

**O. DISLOCATIONS:**

|  |  |  |
| --- | --- | --- |
| 1. Have you ever dislocated a joint? If yes, please fill out the appropriate boxes on the chart below:
 | **YES** | **NO** |
|  | RIGHT | **LEFT** | **# OF TIMES** | **DATES** |  | **RIGHT** | **LEFT** | **# OF TIMES** | **DATES** |
| SHOULDER |  |  |  |  | ELBOW |  |  |  |  |
| A-C JOINT |  |  |  |  | WRIST |  |  |  |  |
| KNEE CAP |  |  |  |  | HIP |  |  |  |  |
| KNEE |  |  |  |  | FINGERS |  |  |  |  |
| NECK |  |  |  |  | TOES |  |  |  |  |
| ANKLE |  |  |  |  |  |  |  |  |  |
| 1. Have you ever had surgery for a dislocation? If yes, describe surgery type, date, physician, and location of hospital below
 |

**P. MUSCLE or TENDON INJURIES:**

|  |  |  |
| --- | --- | --- |
| 1. Have you ever had a severe muscle pull or strain or tendon tear?
 | YES | **NO** |
| 1. Have you ever had compartment syndrome? If yes, provide details and date(s):
 | YES | **NO** |
| 1. Has this injury reoccurred? If yes, list the muscle(s) involved and date(s):
 | YES | NO |

**Q. NECK:**

|  |  |  |
| --- | --- | --- |
| 1. Have you ever sustained a serious neck or cervical injury?
 | YES | **NO** |
| 1. Did you have numbness, burning, or sharp pain in your arms or legs?
 | **YES** | **NO** |
| 1. Have you ever had an injury producing weakness or numbness of your arms or legs or both?
 | **YES** | **NO** |
| 1. Were you ever transported by ambulance for a neck injury?
 | **YES** | **NO** | If yes, did you have neck or spinal X-Rays taken? | YES | **NO** |
| 1. Have you ever had neck surgery? If yes, describe surgery type, date, physician, and location of hospital below:
 | **YES** | **NO** |
| 1. Have you ever had a burner or stinger (stretched or pinched nerve)?
 | **YES** | **NO** |
| 1. Do you currently have any weakness due to a neck or spinal injury? If yes, give the location(s) of the weakness.
 | **YES** | **NO** |

**R. SPINE:**

|  |  |  |
| --- | --- | --- |
| 1. Have you ever injured your back? If yes, how many times? Please provide details regarding each injury including dates, treatment, rehabilitation, etc.
 | **YES** | **NO** |
| 1. Were you ever diagnosed with a spinal defect of any type? If yes, provide details of defect?
 | **YES** | **NO** |
| 1. Have you ever had back surgery? If yes, describe surgery type, date, physician, and location of hospital below.
 | **YES** | **NO** |

**S. SHOULDERS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Have you ever had a significant shoulder joint injury?
 | L | R | **YES** | **NO** |
| 1. Have you ever had an A-C sprain or separation?
 | L | R | **YES** | **NO** |
| 1. Has your shoulder ever felt like it was unstable or slipping?
 | L | R | **YES** | **NO** |
| 1. Have you ever had a problem with your shoulder repeatedly coming out of place?
 | L | R | **YES** | **NO** |
| 1. Do you have any problems with your shoulder when trying to throw?
 | L | R | **YES** | **NO** |
| 1. Do you have any problems with your shoulder with overhead activities?
 | L | R | **YES** | **NO** |
| 1. Have you ever had shoulder surgery? If yes, describe surgery type, date, physician, and the location of hospital below.
 | L | R | **YES** | **NO** |

**T. ELBOW, FOREARM, WRIST, HAND, FINGER:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Have you ever had an elbow injury or problem?
 | L | R | **YES** | **NO** |
| 1. Have you ever had a forearm injury or problem?
 | L | R | **YES** | **NO** |
| 1. Have you ever had a wrist injury or problem?
 | L | R | **YES** | **NO** |
| 1. Have you ever had a problem with hand or finger injury?
 | L | R | **YES** | **NO** |
| 1. Do you have a finger deformity as a result of this injury? If so, which finger?
 | L | R | **YES** | **NO** |
| 1. Have you ever had elbow, wrist, or hand/finger surgery? If yes, describe surgery type, date, physician, and the location of hospital below.
 | **YES** | **NO** |

**U. KNEES:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Have you ever had a significant knee injury? If yes, please describe the injury(s) you have sustained?
 | L | R | **YES** | **NO** |
|  If you have had a significant knee injury or knee surgery, answer the following questions:1. Were you placed on a rehabilitation program?
 | **YES** | **NO** |
| 1. Do you wear any type of preventative/protective brace when you practice or play?
 | **YES** | **NO** |
| 1. Does your knee ever swell or collect fluid?
 | L | R | **YES** | **NO** |
| 1. Did you have surgery for your knee injury(s)?
 | L | R | **YES** | **NO** |
|  If yes, please describe the surgery type, date, physician, and the location of the hospital where surgery was performed. |
| 1. Have you had surgery on either knee more than once?
 | L | R | **YES** | **NO** |
| 1. Have you ever suffered from patellar tendinitis or jumper’s knee?
 | L | R | **YES** | **NO** |
| 1. Have you ever been diagnosed with Osgood-Schlatter’s disease?
 | L | R | **YES** | **NO** |

**V. ANKLES:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Have you ever sustained a severe ankle sprain?
 | L | R | **YES** | **NO** |
| 1. Have you ever sustained a “high ankle sprain” or syndesmosis sprain?
 | L | R | **YES** | **NO** |
| 1. Have you ever had surgery on your ankle(s)? If yes, describe the surgery type, date, physician, and location of the hospital below.
 | L | R | **YES** | **NO** |

**W. FEET AND TOES:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Have you ever had a problem with bunions?
 | L | R | **YES** | **NO** |
| 1. Have you ever had a Lisfranc or mid-foot sprain?
 | L | R | **YES** | **NO** |
| 1. Have you ever had a problem with turf toe or sprained great toe?
 | L | R | **YES** | **NO** |
| 1. Have you ever had a problem with ingrown toenails?
 | L | R | **YES** | **NO** |

**X. OTHER:**

If you have any additional conditions, problems, or comments that have not been addressed thoroughly in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our best medical care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no medical history, abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

**DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRINTED NAME OF ATHLETE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(First) (Middle) (Last)**

**DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF ATHLETE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Pre-Participation Physical Exam

Stop here! Please do not complete anymore. The remainder of this form is for the Athletic Training and Sports Medicine staff to complete.

|  |
| --- |
| **HEIGHT:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **WEIGHT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **BODY COMPOSITION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_% \_\_\_\_\_\_\_\_(Formula) |
| **NECK**: ROM: Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SHOULDER**: ROM: R) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; L) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Deltoid Strength R) Good ( ) Weak ( ) Supraspinatus R) Good ( ) Weak ( ) L) Good ( ) Weak ( ) L) Good ( ) Weak ( )Internal Rotation R) Good ( ) Weak ( ) External Rotation R) Good ( ) Weak ( ) L) Good ( ) Weak ( ) L) Good ( ) Weak ( ) |
| **ELBOW**: ROM: R) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; L) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **WRIST**: ROM: R) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; L) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **HANDS & FINGERS**: ROM: R) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; L) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Deformities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SPINE**: ROM: R) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; L) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Posture: ( ) Normal ( ) Scoliosis ( ) Kyphosis ( ) LordosisPhysician Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **HIP**: ROM: R) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; L) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Psoas Muscle: R): Tight, Flexible Rectus Femoris: R): Tight, Flexible L): Tight, Flexible L): Tight, FlexibleHamstring: R): Tight, Flexible \_\_\_\_\_\_\_\_\_\_\_(degrees) Hip Flexor Strength: R): Strong, Weak L): Tight, Flexible \_\_\_\_\_\_\_\_\_\_\_(degrees) L): Strong, WeakPhysicians Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **KNEE**: ROM: R) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; L) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Right | Left | Comments |  | Right  | Left | Comments |
| Bowleg (Genu Varum) |  |  |  | Plica |  |  |  |
| Knock Knee (Genu Valgum) |  |  |  | Q Angle |  |  |  |
| Back Knee (Genu Recurvatum) |  |  |  | Abduction Stress (30°) |  |  |  |
| Hyperextension Lift |  |  |  | Abduction Stress (0°) |  |  |  |
| Patella Lateral |  |  |  | Adduction Stress (30°) |  |  |  |
| Patella High (Alta) |  |  |  | Adduction Stress (0°) |  |  |  |
| Patella Low (Baja) |  |  |  | Lachman Test |  |  |  |
| Patella Hypermobile |  |  |  | McMurray’s Test |  |  |  |
| Anterior Drawer (ER) |  |  |  | Jerk/Pivot Shift |  |  |  |
|  (N) |  |  |  | VMO Dysplasia |  |  |  |
|  (IR) |  |  |  | Posterior Drawer |  |  |  |
| Physician Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **ANKLE**: ROM: R) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; L) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Right | Left | Comments |  | Right  | Left | Comments |
| Dorsiflexion (with knee fully extended) |  |  |  | Anterior Drawer Test |  |  |  |
| Jump Test |  |  |  | Inversion Stress Test |  |  |  |
|  |  |  |  | Eversion Stress Test |  |  |  |
| Physician Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **FEET & TOES**: ROM: R) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; L) Normal, Restricted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ARCH**: R): NORMAL, HIGH, LOW **REARFOOT:** R): NEUTRAL, PRONATED, SUPINATED L): NORMAL, HIGH, LOW L): NEUTRAL, PRONATED, SUPINATEDPhysicians Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **VISUAL ACUITY:** L)\_\_\_\_\_\_\_\_\_\_ R)\_\_\_\_\_\_\_\_\_\_ (corrected or uncorrected) DOMINANCE: EYE\_\_\_\_\_\_\_\_\_ HAND\_\_\_\_\_\_\_\_\_Contacts:\_\_\_\_\_\_\_\_\_\_\_\_ Glasses:\_\_\_\_\_\_\_\_\_\_\_\_ Are they worn during athletic participation? Yes No |
| GENERAL MEDICAL: |
| **BLOOD PRESSURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PULSE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | **NORMAL** | **ABNORMAL** |  | **NORMAL** | **ABNORMAL** |
| HEAD |  |  | RESPIRATORY |  |  |
| EYES |  |  | HEART |  |  |
| EAR, NOSE, THROAT |  |  | ABDOMEN |  |  |
| NECK |  |  | URINARY |  |  |
| SKIN |  |  | OTHER |  |  |
| Physicians Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DENTAL: |
| **URINALYSIS:** | Glucose | Bilirubin | Ketone | SG | Blood | Ph | Protein | Urobilinogen | Nitrate | Leukocytes |
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OVERALL PHYSICAL EXAMINATION RESULTS:

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| RESULTS | **CHECK ONE** | **COMMENTS** |
| PASSED WITHOUT LIMITATIONS |  |  |
| **PASSED PENDING THE FOLLOWING:** |  |  |
| **FAILED DUE TO THE FOLLOWING:** |  |  |
| **At this date, I can find no physical abnormality that would deter this student from fully participating in all of the sports listed below, except the ones that are circled:** | Badminton, Baseball, Basketball, Cheerleading, Cross Country, Football, Golf, Rodeo, Soccer, Softball, Swimming, Tennis, Track & Field, Volleyball, Weight Training, Wrestling |

**Physician's Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician's Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Clinicians Comments & Concerns on Physical Examination:** |
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| **Clinicians Recommendations on Physical Examination:** |
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| **Clinicians Comments & Concerns on Medical History:** |
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| **Clinicians Recommendations on Medical History:** |
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