Pre-Participation Physical Evaluation: Medical History Form

This Medical History Form must be completed annually by parent/guardian (if under age 18) and athlete in order for the athlete to participate in athletic activities. These questions are designed to determine if the athlete has developed any condition which would make it hazardous to participate in an athletic event.

Full Name_____ Sex____ Age____ Date of Birth___/___/__

Address_____ City_____ State Zip Code_____

Sports (circle all that apply):

Volleyball	Men's Soccer	Men's Basketball	Baseball	Men's Track	Intramurals
Women's Soccer	Women's Basketball	Softball	Women's Track	Cheerleading	Student Athletic Trainer

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST, BOTH IN-SEASON OR OUT-OF-SEASON.

Answer ALL questions by checking the YES or NO boxes. Explain ALL "Yes" answers in the space below. Some questions answered with "Yes" require further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participating in HT athletic practices, scrimmages or contests.

GENERAL MEDICAL HISTORY	y	N
1. Have you had a medical illness or injury since your last check up or sports physical?	D	D
2. Have you been hospitalized overnight in the past year?	D	D
3. Have you ever had surgery?	D	D
4. Are you currently taking any prescriptions or non-prescription (over the counter) medications or pills?	D	D
5. Do you have any allergies (pollen, medicine, food or insects)?	D	D
6. Do you have seasonal allergies that require medical attention?	D	D
7. Have you had a severe viral infection (ex: myocarditis or mononucleosis) within the last month?	D	D
8. Do you have any current skin problems (ex: itching, rashes, acne, warts, fungus or blisters)?	D	D
9. Have you had any problems with your eyes or vision?	D	D
10. Have you had any problems with your ears or hearing?	D	D
11. Are you missing any paired organs?	D	D
12. Have you or anyone in your family been diagnosed with sickle cell or sickle cell trait?	D	D
13. Have you ever been diagnosed with ADD/ADHD? If yes, see additional form.	D	D
14. Have you ever become ill from exercising in the heat?	D	D
15. Do you cough, wheeze, or have trouble breathing during or after exercise?	D	D
16. Do you have asthma?	D	D
17. Do you use an inhaler?	D	D
18. Do you want to weigh more or less than you do now?	D	D
19. Do you fear becoming fat?	D	D
20. Have you made repeated attempts to diet or restrict your eating?	D	D
21. Do you feel fat even though friends and family say you are not?	D	D
22. Do you feel overly stressed, anxious or depressed?	D	D
23. Are you under a doctor's care?	D	D

HEAD INJURY HISTORY	y	N
1. Have you ever had a head injury or concussion?	D	D
2. Have you ever been knocked out, lost consciousness, or lost your memory? ____ ____	D	D
If yes, how many times?		
When was your last concussion? _____		

HEAD INJURY HISTORY, cont'd	Y	N
7. How severe was each one? (Explain below)_____		
8. Do you have frequent headaches?	D	D
9. Have you ever had numbness or tingling in your arms, hands, legs or feet?	D	D
10. Have you ever had a stinger, burner or pinched nerve?	D	D

CARDIAC HISTORY		
1. Have you ever passed out during or after exercise?	D	D
2. Have you ever been dizzy during or after exercise?	D	D
3. Have you ever had chest pain during or after exercise?	D	D
4. Do you get tired more quickly than your friends do during exercise?	D	D
5. Have you ever had racing of your heart or skipped heartbeats?	D	D
6. Have you had high blood pressure or high cholesterol?	D	D
7. Have you ever been told you have a heart murmur?	D	D
8. Has any family member been diagnosed with an enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?	D	D
9. Has a physician ever denied or restricted your participation in sports for any heart problems?	D	D

ORTHOPEDIC HISTORY		
1. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position?	D	D
2. Have you ever had a sprain or strain?	D	D
3. Have you broken or fractured any bones or dislocated any joints?	D	D
4. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	D	D

If yes, circle appropriate area and explain below:

Head Shoulder Upper Arm Elbow Hand Finger Wrist Chest
Thigh Forearm Shin/Calf Back Hip Knee Neck Ankle

FEMALES ONLY

1. When was your first menstrual period? _____
2. When was your most recent menstrual period? _____
3. How much time do you usually have from the start of one period to the start of another? _____
4. What was the longest time between periods in the last year? _____
5. How many periods have you had in the last year? _____

Please explain "YES" answers from above: _____

If, between this date and the beginning of athletic competition, any illness or injury occurs that may limit my participation, I agree to notify the HT Athletic Training Staff.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide untruthful responses could subject me, the athlete in question, to penalties determined by the Huston-Tillotson Athletics Department.

Athlete Signature: Parent/guardian Signature: Date signed:

Pre-Participation Physical Evaluation: Physical Examination Form

THIS PAGE MUST BE COMPLETED BY THE LICENSED MEDICAL PROFESSIONAL CONDUCTING THE PHYSICAL EXAMINATION

Must be completed before an athlete participates in any practice, scrimmage , or contest, either in-season or out-of-season.

Name:_____ Sex:_____ Age: _____ Date of Birth:_____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse:_____ BP:_____ ___ - __

Brachial blood pressure while sitting

Vision : R 20/_____ L 20/ Corrected: D Yes D No If yes, with? D Glasses D Contacts Pupils: D Equal D Unequal

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart- Auscultation of the heart in the supine position.			
Heart- Auscultation of the heart in the standing position.			
Heart - Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia - (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum joint, hypermobility, scoliosis)			
MUSCULOSKELET AL	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back/Spine			
Shoulders/Arms			
Elbows/Forearms			
Wrist/Hand			
Hips/Thighs			
Knees			
Legs/Ankles			
Feet			

*Station-based Examination Only

CLEARANCE

D Cleared

D Cleared after completing evaluation/rehabilitation for : _____

D Not cleared for:_____ Reason:_____

Recommendations: _____

The following infomation must be filled in and signed by either a Physician, a Physician Assistant licensed by the State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other profession will not be accepted.

Name:_____ Date of Examination:_____

Address : _____ STAMP

SPhone Number: _____

. Signature: _____