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Athlete History Form

Date of Exam ____________________
Student ID ____________________
Date of Birth ____________________
School ____________________

Name ____
Age _______ Sex _______
Sport(s) ____

Part I: To be completed by the athlete.

Medicines and Allergies: Please list all the prescription and over-the-counter medicines and suplements (herbal and nutritional) that you are currently taking. ____
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Do you have any allergies? ❑ Yes ❑ No If yes, please identify specific allergy below.
❑ Medicines ❑ Pollens ❑ Food ❑ Stinging Insects Please describe: ____________________________

Explain "Yes" answers bellow. Circle questions you don't know the answers

GENERAL QUESTIONS	Yes	No
Has a doctor ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please idenity bellow: ❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections ❑ Other__________________		
Have you ever spent the night in the hospital?		
Have you ever had surgery?		
HEART HEALTH QUESTIONS	**Yes**	**No**
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
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______________________________		
Has a doctor ever ordered a test for your heart? (For example, ECG, EKG, echocardiogram)		
Do you get lightheaded or feel more short of breath then expected during exercise?		
Have you ever had an unexplained seizure?		
Do you get more tired or short of breath more quickly then your friends during exercise?		
Has anyone in your family had unexplained fainting, unexpained seizures, or near downing?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
Have you ever had any broken or fractured bones or dislocated joints?		
Have you ever had any broken or fractured bones or dislocated joints?		
Have you ever had an injury that required x-rays, MRI, CT Scan, injections, therapy, a brace, a cast, or cruches?		
Have you ever had a stress fracture?		
Have you ever been told tat you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		

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Do you regularly use a brace, orthotics, or other assistive device?		
Do you have a bone, muscle, or joint injury that bothers you?		
Do any of your joints become paintful, swollen, feel warm, or look red?		
Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	**Yes**	**No**
Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Have you ever used an inhaler or taken asthma medicine?		
Is there anyone in your family who has asthma?		
Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
Do you have groin pain or any painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores, or other skin problems?		
Have you had a herpes or MRSA skin infection?		
MEDICAL QUESTIONS CONT.	**Yes**	**No**
Have you ever had a head injury / concussion?		
Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
Do you have a history of seizure disorder?		
Do you have headaches with exercise?		
Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
Have you ever become ill while exercising in the heat?		
Do you get frequent muscle cramps when exercising?		
Do you or someone in your family have sickle cell trait or disease?		
Have you had any problems with your eyes or vision?		
Have you had any eye injuries?		
Do you wear any glasses or contact lenses?		
Do you wear protective eyewear, such as googles or a face shield?		
Do you worry about your weight?		
Are you on a special diet or do you avoid certain types of foods?		
Have you ever had an eating disorder?		
Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months?		

Explain "yes" answers here

Signature of Athlete

Date

Signature of Parent/Guardian

Date

Part II: To be completed by a physician.

Physical Examination From

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigaretts, chewing tabacco, snuff, dip, or any E-ciggarets?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14)

EXAMINATION					
Height:	Weight:	Sex			
BP: / (/)	Pulse:	Vision R 20/	L 20/	Corrected: ❑ Y ❑ N	

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodaclyly, arm span > hight, hyperlaxity, myopia, MVP, aortic insuffciency)		
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 (Male only)		
Skin • HSV, lesions, suggestive of MRSA, tinea corporis		
Neurologic		

MEDICAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Sholder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

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- ❑ Cleared for all sports without restriction
- ❑ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

- ❑ Not cleared
  - ❑ Pending furth evaluation
  - ❑ For any sports
  - ❑ For certain sports ______________________________

Reasons ______________________________

Recommendations ______________________________

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I have examined the above-named student and completed the prepartication physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school ar 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)

______________________________ ______________

Name of physician (print/type) Date

______________________________ ______________

Address Phone

EMERGENCY INFORMATION

Allergies ______________________________

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Other Information ______________________________

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