

History



Note: This form is to be filled out by the patient and parent prior to seeing a physician or nurse practitioner.

Date of Exam _____

Last Name _____	First Name _____
Date of birth (dd/mm/yyyy) _____	Grade _____
Male <input type="checkbox"/> Female <input type="checkbox"/>	Sport _____

Medicines and Allergies

Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional that you are currently taking:

Do you have any allergies? Yes No If yes, please specific allergy below.
 Medicines Pollens Food Stinging Insects

Reaction:

General Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any medical conditions? Asthma Anemia Diabetes Infections Other _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>

Heart Health question about you	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your heart ever race or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever told you that you have any heart problems? High blood pressure High cholesterol Kawasaki disease A heart murmur A heart infection Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever ordered a test for your heart? (ECG/EKG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you get lightheaded or feel more short of breath than expected during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had an unexplained seizure?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you get more tired or short of breath more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>

Heart Health question about your family	Yes	No
13. 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)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	<input type="checkbox"/>	<input type="checkbox"/>

Bone and joint questions	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
21. 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)	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace, orthotics, or other assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you have a bone, muscle, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do any of your joints become painful, swollen, feel warm, or look red?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have any history of juvenile arthritis or connective tissue disease?	<input type="checkbox"/>	<input type="checkbox"/>

Medical questions	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		

43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
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 types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		

Females only	Yes	No
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain the "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Date

▶ Signature of Student

▶ Signature of parents

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Physical Examination

Note: This form is to be filled out and signed by a physician or nurse practitioner.

Last Name	First Name
Date of birth (dd/mm/yyyy)	Grade
<input type="checkbox"/> Male <input type="checkbox"/> Female	

Examinations			
Height		Weight	
BP		Pulse	
Authorization for Medication Form Completed			

Medical	Normal	Abnormal findings
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eye / ears / nose / throat • Pupils equal • Hearing R20/ L20/		
Lymph nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulse		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		

Musculoskeletal	Normal	Abnormal findings
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/Toes		
Functional • Duck-walk, single leg hop		

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

Not cleared
Pending evaluation
For any sports
For certain sports

Reason: _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. 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) _____

Address _____ Phone _____

Date _____ Signature _____

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