

PRE - PARTICIPATION SPORTS SCREENING

Name _____ Age _____ Gender _____ Date of Birth _____

Address _____ Phone _____

School _____ Grade _____ Sports _____

Height _____ Weight _____ Personal Physician _____ Physician's Phone _____

Medical History Questionnaire - This section must be completed before your examination. Include dates/age of any problems and explain ALL "Yes" answers in the space below the questions.

	YES	NO		YES	NO
1. Do you have any ongoing medical conditions? <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	19. Have you ever had a sprained, broken, dislocated or repeated swelling or pain of any bones or joints that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	20. Are any joints CURRENTLY bothering you? <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	21. Do you use any special equipment (splints, neck rolls, mouth guards)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you currently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (medicine, bee stings, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have you ever been told you have Sickle Cell Trait or Sickle Cell Disease?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have you had any medical problems or injuries since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had chest pains DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Has a doctor ever Denied or Restricted your participation in sports for any reason? When and why? _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	26. When was your last tetanus vaccine? _____ (FEMALES ONLY)		
9. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your heart ever race or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. If so, how old were you when you had your first menstrual period? _____		
11. Has any family member died of heart problems or had an unexplained sudden death BEFORE age 50?	<input type="checkbox"/>	<input type="checkbox"/>	29. How many periods have you had in the last 12 months? _____		
12. Do you get lightheaded or feel more short of breath than expected during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. What was the longest time between our periods last year? _____		
13. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
17. Do you have any problems with your eyes or vision? Do you wear <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Eye Protection?	<input type="checkbox"/>	<input type="checkbox"/>			
18. Do you have only one working organ of usually paired organs (such as only one eye, kidney, testicle, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>			

Explain all "Yes" answers by question number and indicate date/age for each item (Example: #3: Right arm fracture in 2015):

I/We hereby state that, to the best of my/our knowledge, the answers to the above questions are correct. I/We understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this Individual.

Signature of Athlete _____ Date _____

Signature of Parent or Guardian (if athlete is under 18) _____ Date _____

	Blood Pressure	HEENT	Skin	Heart	Lungs	Musculoskeletal	Flexibility/Strength
NORMAL							
ABNORMAL							

While this does not constitute a complete physical examination nor replace the need for periodic health evaluations by a family physician, this individual appears to be physically capable of participation in interscholastic sports as of this date, except as indicated below.

☐ Cleared for sports without restrictions: _____

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not Cleared

At this athlete's screening exam, the following is/are noted:

Condition/Sign/Symptoms with Simple Explanation/Recommendations

☐ Elevated (High) Blood Pressure. Increase in pressures in the artery during the beating and resting heart. Maximum normal (age group) ____ / ____

☐ Heart Murmur. Flow of blood through the heart which is audible. In this case, it is: 0 "Functional" (normal) 0 Abnormal.

☐ Asthma. Blockage of small airways in the lung. ☐ Use inhaler as prescribed and 30 minutes before exercise.

☐ Allergic Reactions to Stings or Bites. (includes whole body swelling & shortness of breath) ☐ Epinephrine injector should be available at all times.

☐ Diabetes. Abnormal sugars and sugar metabolism. ☐ Continue close monitoring with M.D.

☐ Scoliosis. Curvature of the spine. ☐ Continue close monitoring with M.D.

☐ Orthopaedic Problem. Being seen by M.D. for this condition. ☐ Should be cleared for play by M.D.

☐ Concussion. Further evaluation required before athletic participation permitted.

☐ Other: _____

Physician's Name: _____ Physician's Signature: _____ Date: _____