HMH SPORTS MEDICINE PHYSICAL FORM

MEDICAL HISTORY QUESTIONNAIRE AND PREPARTICIPATION PHYSICAL EXAM (7/11)

NAME_____DATE_____
Last First Middle

Sport _____Soc. Sec. #_____ ECTC ID _____

Birth Date_____ Age_____

Sex _____Male Marital Status _____Single

_____Female _____Married

Cell No._____

Mother/Guardian Contact Information

Name_____

Address_____

_____ _____ _____
City State Zip code

Phone (H)_____Cell #_____

Father/Guardian Contact Information

Name_____

Address_____

_____ _____ _____
City State Zip code

Phone (H)_____Cell #_____

Primary Mailing Address
CHECK ONE:

_____Mother/Guardian
_____Father/Guradian

Instructions: Circle yes or no for each question. When the answer is yes, **please give details and dates.** *This information will be kept confidential.*

MEDICAL HISTORY AND FAMILY MEDICAL HISTORY

yes no 1. Has a doctor ever denied or restricted your participation in sports for any reason?

yes no 2. Do you have an ongoing medical condition like diabetes or asthma?

yes no 3. Are you presently taking any prescription medication or nonprescription (over-the-counter medicine or pills?

yes no 4. Do you have any allergies to medicines, pollens, foods, bees or other stinging insects?

yes no 5. **Have you ever passed out, fainted or nearly passed out DURING exercise?**

yes no 6. **Have you ever passed out, fainted or nearly passed out AFTER exercise?**

yes no 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?

yes no 8. Does your heart race or skip beats during exercise?

yes no 9. Have you ever been told you have a heart murmur? If yes please explain below.

yes no 10. Have you ever been told you have high blood pressure?

yes no 11. Have you ever been told you have a heart infection?

yes no 12. Have you ever been told you have high cholesterol?

yes no 13. Has anyone in your family died for no apparent reason?

yes no 14. Does anyone in your family have a heart problem?

yes no **15 Has any family member or relative died of heart problems or of sudden death before age 50?**

yes no **16. Has anyone in your family had hypertrophic cardiomyopathy or dilated cardiomyopathy, long QT syndrome or Marfan's syndrome?**

yes no 17. Have you ever spent the night in a hospital?

yes no 18. Have you ever had surgery? If yes, please explain below.

yes no 19. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? **If yes, list what body part.**

yes no 20. Have you had any broken or fractured bones or dislocated joints? What part?

yes no 21. Have you had a bone or joint injury that required x-rays, MRI, CT Scan, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, list.

yes no 22. Have you ever had a stress fracture?

yes no 23. Have you ever injured your neck or back?

yes no 24. Have you ever been told that you have or have you had an x-ray for atlantoaxial neck instability?

yes no 25. Do you regularly use any special equipment (pads, braces, neck rolls, or assistive devices?

yes no 26. Hs a doctor ever told you that you have asthma or allergies?

yes no 27. Do you cough, wheeze, or have difficulty breathing during or after exercise?

yes no 28. Is there anyone in your family who has asthma?

yes no 29. Have you ever used an inhaler or taken asthma medicine?

yes no 30. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?

yes no 31. Have you had infectious mononucleosis (mono) within the last year?

yes no 32. Do you have any rashes, sores or other skin problems?

yes no 33. Have you had a herpes skin infection?

yes no 34. Have you ever had a head injury or concussion?

yes no 35. Have you ever been knocked out or unconscious?

yes no 36. Have you ever been hit in the head and been confused or lost your memory?

yes no 37. Have you ever had a seizure?

yes no 38 Do you have headaches with exercise? With weight lifting?

yes no 39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?

yes no 40. Have you ever had "stingers" or " burners" when being hit?

yes no 41. When exercising in the heat, do you have severe muscle cramps or become ill?

yes no 42. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?

yes no 43. Have you had any problems with your eyes or vision?

yes no 44. Do you wear glasses or contact lenses?

yes no 45. Are you happy with your present weight?

yes no 46. Are you trying to lose or gain weight?
yes no 47. Have you ever tried weight control by vomiting or laxative use?

yes no 48. Has anyone recommended you change your weight or eating habits?

yes no 49. Do you exclude any foods from your diet (meats, milk)?

yes no 50. Are you presently taking any food supplements?

yes no 51. Do you limit or carefully control what you eat?

yes no 52.. Do you know of any health reason that you should not participate in athletics?

yes no 53. **Are you ill in any way at this time?**

yes no 54. Do you have any concerns that you would like to discuss with a doctor?

yes no 55. Are you prescribed medication for ADHD (Attention Deficit Hyperactivity Disorder)?

FEMALE ATHLETES ONLY

yes no 56. Have you ever had a menstrual period?

yes no 57. How old were you when you had your first menstrual period?_____

yes no 58. How many periods have you had in the last 12 months?_____

ALL ATHLETES

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

I am aware of the risks of injury that I assume by participating in athletics including severe injuries that could result in paralysis or death.

I give my permission to the athletic trainers to release my medical records and insurance information to the team physicians or to those physicians and medical facilities that they may refer me to with regard to injury or illness.

DATE: _____ ATHLETE'S SIGNATURE: _____

PARENT'S SIGNATURE: _____

******THE BACK PAGE IS THE PHYSICAL EXAM FORM AND WILL BE FILLED OUT by the PHYSICIAN**

PREPARTICIPATION PHYSICAL EXAMINATION FOR ATHLETICS

NAME _____ **SPORT** _____

DATE OF EXAM _____ **HEIGHT** _____ **WEIGHT** _____

BLOOD PRESSURE _____/_____ **PULSE** _____/minute

	Normal	Abnormal	Remarks
EYES			
HEART (Standing & Suppine)			
LUNGS			
PULSES (Femoral & Radial)			
ABDOMEN			
MUSCULOSKELETAL			

Physician's NAME Dr. _____

Physician's Signature Dr. _____

_____ Cleared to participate

_____ Cleared after further evaluation

_____ Orthopedic evaluation needed

_____ Cardiac evaluation needed

_____ Other evaluation needed _____

_____

_____ Other eval completed Date _____ Physician _____