Club Sports Medical History & Physical Form

Name:

Sport:

DOB:

Year:

Height:	**Weight:**	**Age:**	**Male ☐ Female ☐**
BP: /	**Resting Pulse:**	**Vision:** R 20/ L 20/	Corrected: Y/N

PART 1: PHYSICAL

MEDICAL	**Normal**	**Abnormal Findings**
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males)		
Skin		
Neurologic		
MUSKULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional		

Medical Practitioner to Club Sports AT's (please indicate any instructions or recommendations here)

Emergency medication requid on-site: ☐Inhaler ☐Epinephrine ☐Glucagon ☐Other:

Comments:	History of Concussion:
	Number of Concussions:
	Most Recent Concussion:

I have reviewed the medical history & data above & make the following recommendations for athletic participation

☐**CLEARED WITHOUT RESTRICTIONS**
☐**CLEARED WITH FOLLOWING NOTATION:**
☐Cleared **AFTER** documentation/ further evaluation or treatment for:
☐**NOT CLEARED FOR PARTICIPATION:** (Reason)

Examiner's Name & degree (print):	**Signature:**
Address:	**Phone Number:**

Only signatures of MD, DO, NP or PA licensed to practice in the U.S. will be accepted.

PART 2: MEDICAL HISTORY

This section MUST be completd and signed prior to the physical examination for practitioner review.

1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐**Yes**	☐**No**
2. Do you currently have an ongoing medical condition?	☐**Yes**	☐**No**
3. Have you ever been hospitalized overnight or had a surgery?	☐**Yes**	☐**No**
4. Are you currently taking any daily medications? (list)_____	☐**Yes**	☐**No**
5. Have you ever passed out or nearly passed out during or after exercise?	☐**Yes**	☐**No**
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐**Yes**	☐**No**
7. Does your heart race or skip beats during exercise?	☐**Yes**	☐**No**
8. Has a doctor ever told you that you have: (circle) High Blood Pressure, High Cholesterol, Kawasaki Disease, Heart Murmur, Heart Infection, Other Heart Issue.	☐**Yes**	☐**No**
9. Has a doctor ever ordered a test for your heart? (ECG/EKG, echocardiogram)	☐**Yes**	☐**No**
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐**Yes**	☐**No**
11. Have you ever had an unexplained seizure?	☐**Yes**	☐**No**
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50?	☐**Yes**	☐**No**
13. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	☐**Yes**	☐**No**
14. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?	☐**Yes**	☐**No**
15. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis?	☐**Yes**	☐**No**
16. Have you had any broken/fractured bones or dislocated joints?	☐**Yes**	☐**No**
17. Have you had an injury requiring advanced imaging, surgery, injection, physical therapy, brace/cast, crutches'	☐**Yes**	☐**No**
18. Have you ever been told you have a disorder or any neck/spine problem?	☐**Yes**	☐**No**
19. Have you ever had a stress fracture of a bone?	☐**Yes**	☐**No**
20. Do you regularly use a brace or assistive device?	☐**Yes**	☐**No**
21. Do you currently have a bone, muscle, or joint injury that bothers you?	☐**Yes**	☐**No**
22. Do you have a history of juvenile arthritis or connective tissue disease?	☐**Yes**	☐**No**
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐**Yes**	☐**No**
24. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	☐**Yes**	☐**No**
25. Were you born without or are you missing a kidney, eye, testicle, spleen or other organ?	☐**Yes**	☐**No**
26. Have you had mononucleosis (mono) or other viral infection in the past month?	☐**Yes**	☐**No**
27. Do you have an skin problems? (rash, warts, fungus, itching, etc)	☐**Yes**	☐**No**
28. Have you ever had a herpes or MRSA skin infection?	☐**Yes**	☐**No**
29. Have you ever had a head injury or concussion? How many? _____ Date most recent? _____	☐**Yes**	☐**No**
30. Do you have headaches with exercise?	☐**Yes**	☐**No**
31. Have you ever had numbness, tingling, weakness or inability to move your arms or legs following injury?	☐**Yes**	☐**No**
32. When exercising in heat, do you have severe muscle cramps or become ill?	☐**Yes**	☐**No**
33. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐**Yes**	☐**No**
34. Have you had any other blood disorders?	☐**Yes**	☐**No**
35. Have you had any problems with your eyes/vision? (circle) Glasses Contacts Sport Goggle	☐**Yes**	☐**No**
36. What is the date of your last T-dap or tetanus immunization? (Circle type) Date: _____	☐**Yes**	☐**No**
37. Do you have an allergy to medicine, food or stinging insects?	☐**Yes**	☐**No**
38. Do you want to weigh more or less than you do now?	☐**Yes**	☐**No**
39. Have you ever been diagnosed with an eating disorder?	☐**Yes**	☐**No**

Females: How many periods have you had in the last 12 months? _____ Most recent? _____

Explain "Yes" answers (include question number)

Athlete Name (print): **Signature:** **Date:**