



Date _____
 Birthdate _____
 Student _____
 Grade _____ Age _____ Male _____ Female _____

Home Address _____
 City/Zip _____
 Phone _____
 Email _____

Pre-Participation Sports Health Exam

Medical History

- | | | |
|---|-----|----|
| 1. Have you ever had a serious medical problem requiring surgery, hospitalization or prolonged treatment by a doctor? | Yes | No |
| 2. Do you take any medication of any type? | Yes | No |
| 3. Have you ever had a severe allergic reaction to anything? | Yes | No |
| 4. Have you ever had allergic problems such as hay fever, asthma or eczema? | Yes | No |
| 5. Do you have difficult breathing or wheezing during or shortly after exercising? | Yes | No |
| 6. Have you ever had a heart murmur, racing heart or irregular heart beat? | Yes | No |
| 7. Have you ever been dizzy or passed out during exercise? | Yes | No |
| 8. Has any family member ever had a heart attack or died suddenly before age 50? | Yes | No |
| 9. Do you have chest pain or tire more easily than others your age when exercising? | Yes | No |
| 10. Have you ever suffered heat related problems such as heat cramps, severe headache, dizziness or passing out? | Yes | No |
| 11. Have you ever had a significant injury such as a sprain, fracture or dislocation to a bone or joint? | Yes | No |
| 12. Have you ever had a concussion or been knocked unconscious? | Yes | No |
| 13. Have you ever had a seizure? | Yes | No |
| 14. Have you ever had burning pain, numbness or tingling in your arms or legs associated with any athletic or physical activity? | Yes | No |
| 15. Is there any other medical or family history which might be important? | Yes | No |
| 16. Have you ever been taken out of or kept from participating in a sports activity or practice for an injury or physical reason? | Yes | No |
| 17. Have you ever required taping, padding or bracing before events or practice? | Yes | No |
| 18. Do you have damage or absence of one or any paired organs (i.e. kidney, testicle, eye, etc.)? | Yes | No |
| 19. Do you have any skin problems (rash, itching)? | Yes | No |
| 20. In the last year, how much weight have you gained or lost? _____ | | |
| 21. What is the date of your last tetanus booster? _____ | | |
| 22. What is the date of your last MMR? _____ | | |
| 23. Have you ever been diagnosed with sickle cell trait? _____ | | |

For females only

- | | | |
|--|-----|----|
| 24. What is the date of your last menstrual period? _____ | | |
| 25. In the last year have you gone for three months or more without a menstrual cycle? | Yes | No |

Physical

height _____ blood pressure _____ >140/85? _____
 weight _____ pulse _____
 vision L corrected _____ uncorrected _____
 R corrected _____ uncorrected _____
 glasses _____ contact lenses R _____ L _____ both _____
 general observations: _____
 Tanner maturity staging: _____
 HEENT: _____
 Neck: ROM _____ palpation _____ tenderness _____
 Chest: auscultation _____
 wheezing? _____ Rales? _____
 CV: heart murmur _____
 • murmur increase with valsalva? _____
 • murmur grade III or IV? _____
 • murmur diastolic? _____

CV cont.: rhythm _____ click _____ rub _____
 pulses: carotid _____ radial _____ pedal (DP _____ PT _____)
 edema? _____ cyanosis? _____
 Abdomen _____
 *enlarged liver? _____ *enlarged spleen? _____
 hernia? _____ scars? _____
 GU: male _____ testicles R _____ L _____
 female _____
 inguinal hernia? _____
 Skin: gen. _____
 rashes _____ impetigo _____ herpes s. _____
 **MS shoulder _____
 elbow _____
 wrist/hand _____
 back _____
 hip _____
 knee _____
 ankle _____
 feet _____
 other _____

identified problems: 1. _____
 2. _____
 3. _____

recommendations coach/trainer: _____

 *Marfan? >2 (tall _____ striae _____ hyper extensibility _____
 upper to lower body ratio <0.9 _____ lens dislocation _____

*requires additional evaluation
 **detailed exam if history of injury or problem

The above named individual has been cleared for participation in the following sports:

- _____ Contact collision (football, soccer, wrestling, etc.)
 _____ Limited contact impact (baseball, basketball, volleyball)
 _____ Noncontact strenuous (track, field, running, tennis, etc.)
 _____ Non-contact moderately strenuous (badminton, table tennis)
 _____ Non-contact non-strenuous (golf, archery, riflery)

Additional evaluation suggested:

- _____ none
 _____ coach/trainer notification and clearance
 _____ physician
 _____ family physician _____
 _____ sports physician _____
 _____ orthopedic surgeon _____
 _____ other _____

Physician's signature _____ Date _____

Advanced Nurse Practitioner's signature _____ Date _____
 (Physician's Signature must appear also, if examination is given by
 Advanced Nurse Practitioner in written collaborative practice with physician).