THIS QUESTIONAIRE IS FOR PATIENT'S MEDICAL RECORD ONLY DO NOT RETURN TO SCHOOL
PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT

SPORTS PHYSICAL PHYSICIAN OFFICE FORM

Name: _____ Date of Birth: _____ Student ID: _____

Sports: _____ School: _____ Grade: ____ Male ☐ Female ☐

EXPLAIN YES ANSWERS BELOW CIRCLE QUESTIONS YOU DO NOT UNDERSTAND

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports?	☐	☐
2. Do you have a medical condition (asthma/diabetes)?	☐	☐
CARDIAC RISK:		
1. Has any relative died of a heart condition suddenly before age 50?	☐	☐
2. Do you or your relatives have a history of:		
a. Heart muscle disease such as hypertrophic cardiomyopathy?	☐	☐
b. Arrhythmia, irregular rhythm, pacemaker WPW (Wolf Parkinson White), Long QT syndrome or other cardiac problem?	☐	☐
c. Marfan Syndrome?	☐	☐
3. Does your heart race or skip beats during exercise?	☐	☐
4. Have you ever had chest pain during exercise?	☐	☐
5. Have you ever passed out or nearly passed out during or after exercise?	☐	☐
6. Do you have a history of high blood pressure?	☐	☐
7. History of a heart murmur (other than innocent murmur) or other heart problem?	☐	☐
8. History of unexplained dizziness with exercise?	☐	☐
9. Have you ever had an ECG or Echocardiogram test for your heart?	☐	☐
10. History of congenital heart disease?	☐	☐
11. History of Carditis or Kawasaki disease?	☐	☐
RESPIRATORY RISK:		
1. History of cough, wheezing, or difficulty breathing during or after exercise?	☐	☐
2. Have you ever used an inhaler or taken asthma medication?	☐	☐
3. Do you have a history of severe allergies to pollens, stinging insects, foods, or grasses?	☐	☐
4. Have you ever been told by a doctor that you have asthma?	☐	☐
5. History of fractured ribs in the last 6 weeks?	☐	☐
NEUROLOGICAL RISK:		
1. History of head or neck injury, or concussion?	☐	☐
2. Have you ever had amnesia or memory loss after a head injury?	☐	☐
3. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or or falling?	☐	☐
4. History of seizures?	☐	☐
5. History of headaches with exercise?	☐	☐
6. Do you have a history of any problems with your eyes or vision?	☐	☐
7. Do you wear glasses or contact lenses?	☐	☐
8. History of neck instability (i.e. Atlantoaxial Instability)	☐	☐

INFECTION RISK:	Yes	No
1. Do you have a history of recurrent or persistent rashes, pressure sores, herpes, or other skin infections?	☐	☐
2. Have you ever been diagnosed or treated for a MRSA infection?	☐	☐
3. History of Mono (EBV) in the last 4 weeks?	☐	☐
4. History of recurrent unexplained fevers, or chronic coughing?	☐	☐
5. Do you or any members of your household have a history of tuberculosis or positive PPD?	☐	☐
6. History of Hepatitis?	☐	☐
7. History of HIV?	☐	☐
ORTHOPEDIC RISK:		
1. Have you ever broken any bones?	☐	☐
2. History of neck or back injury?	☐	☐
3. History of chronic back or neck pain?	☐	☐
4. History of ankle, knee, hip injury?	☐	☐
5. History of wrist, elbow, shoulder injury?	☐	☐
6. Do you have any artificial limbs or prosthetic devices (false teeth)?	☐	☐
OTHER PERTINENT QUESTIONS:		
1. Are you taking any prescription or nonprescription (over the counter) medicines or pills?	☐	☐
2. Are you taking supplements or medications to gain or lose weight?	☐	☐
3. Are you taking medications or supplements to increase your strength or improve your sports performance?	☐	☐
4. Are you trying to gain or lose weight?	☐	☐
5. Were you born without or are you missing a kidney, eye, (if male testicle), (if female ovary) or other organ?	☐	☐
6. History of bleeding or clotting disorder?	☐	☐
7. History of severe muscle cramps or feeling severely ill when exercising in the heat?	☐	☐
8. History of surgery?	☐	☐
9. History of enlarged liver or spleen?	☐	☐
10. History of sickle cell disease/trait?	☐	☐
11. History of Hypoglycemia (low blood sugar)?	☐	☐
12. Any medical changes since your last physical?	☐	☐
FEMALES OLDER THAN 16 (OPTIONAL):		
1. Have you had no periods?	☐	☐
2. Have you gone more than 90 days without a period in the last 6 months?	☐	☐

EXPLAIN "YES" ANSWERS HERE: _____

_____

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

Signature of athlete: _____ **Signature of parent/guardian:** _____ **Date:** _____

SPORTS PHYSICAL SCHOOL FORM

I grant permission to release the information below to School Personnel.

Signature of Parent/Guardian: _____

NAME: _____ Date of Birth: _____ Student ID: _____

Sports: _____ School: _____ Grade: _____

Emergency Contact: _____ Cell Phone: _____ Home Phone: _____

ALLERGIES: _____ MEDICATIONS: _____

Date of Exam: _____ Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: ____/____

HEARING: ☐ Passed Right/Left ≤25dcbls (all frequencies) ☐ Failed_____ ☐ Not Done

Vision: R 20/___ L 20/___ Both 20/___ Corrected: ☐ Y ☐ N

U/A: ☐ Normal _____

REQUIRED IMMUNIZATIONS: Measles, Mumps, Rubella, Hepatitis B, Polio, Tetanus, Pertussis, and Varicella/illness.

☐ Up to date (See Attached Vaccine Documentation) ☐ Not up to date, Vaccines Needed: _____

☐ Baseline Concussion Assessment Complete (recommended, if not done, school will conduct the screening)

MEDICAL:	NORMAL	ABNORMAL FINDINGS
General Appearance		
Head eyes/ears/nose/throat		
Neck		
Respiratory		
Heart		
Pulses		
Abdomen		
Skin		
Neuro		
Lymph Nodes		
Genitourinary (males only)		

MUSCULOSKELETAL:	NORMAL	ABNORMAL FINDINGS
Back (including scoliosis screen)		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

Assessment/Plan: _____

OFFICE STAMP:

☐ Cleared for all sports without restrictions

☐ Not Cleared for: ☐ All sports ☐ Certain sports:_____

Reason:_____

☐ Deferred requires further evaluation (See Recommendations Below):

☐ Cleared with restrictions (See Recommendations Below):

Recommendations: _____

Name of Physician (print):_____ Address: _____ Phone: _____

Signature of Physician:_____, M.D., D.O., or N.P. Date:_____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.

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