

HISTORY FORM



(Note: This form is to be filled out by the patient and parent prior to examination. The examiner should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.
 Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			39. Have you ever been unable to move your arms or legs after being hit or falling?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			40. Have you ever become ill while exercising in the heat?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			41. Do you get frequent muscle cramps when exercising?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			42. Do you or someone in your family have sickle cell trait or disease?		
BONE AND JOINT QUESTIONS	Yes	No	43. Have you had any problems with your eyes or vision?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			44. Have you had any eye injuries?		
18. Have you ever had any broken or fractured bones or dislocated joints?			45. Do you wear glasses or contact lenses?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			46. Do you wear protective eyewear, such as goggles or a face shield?		
20. Have you ever had a stress fracture?			47. Do you worry about your weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			48. Are you trying to or has anyone recommended that you gain or lose weight?		
22. Do you regularly use a brace, orthotics, or other assistive device?			49. Are you on a special diet or do you avoid certain types of foods?		
23. Do you have a bone, muscle, or joint injury that bothers you?			50. Have you ever had an eating disorder?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			51. Do you have any concerns that you would like to discuss with a doctor?		
25. Do you have any history of juvenile arthritis or connective tissue disease?			FEMALES ONLY		
			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 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 _____

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PHYSICAL EXAMINATION FORM



(The physical examination must be performed on or after April 1 by a physician holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) – IHSAA By-Law 3-10

Name _____ Date of birth _____

1. Consider additional questions on more sensitive issues
- Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP	Pulse	Vision R 20/	L 20/
		Corrected	<input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance			
• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat			
• Pupils equal			
• Hearing			
Lymph nodes			
Heart			
• Murmurs (auscultation standing, supine +/- Valsalva)			
• Location of point of maximal impulse (PMI)			
Pulses			
• Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
• HSV, lesions suggestive of MRSA, linea corporis			
Neurologic			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/leg			
Knee			
Leg/ankle			
Foot/toes			
Functional			
• Duck-walk, single leg hop			

Consider ECG, echocardiogram, and referral to cardiology for all normal cardiac history or exam
 Consider GU exam if in private setting. Having third party present is recommended.
 Consider cognitive evaluation or baseline neuropsychologic testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians). (The physical examination must be performed on or after April 1 by a physician holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) – IHSAA By-Law 3-10

Name of physician (print/type): (MD, DO, NP, or PA) _____ Date _____
 Address _____ Phone _____
 Signature of physician (MD, DO, NP, or PA) _____ License # _____