Medical Evaluation Form: B **HISTORY**

Name _____ **Sex**_____ **Age**_____ **Date of Birth**_____
School_____ **Grade/Year**_____ **Sports**_____
Address_____ **Phone**_____
Personal Physician_____ **Address**_____
Insurance_____ **Policy Number**_____
In case of emergency, contact
Name_____ **Relationship**_____ **Phone**_____

Explain "yes" answers below.	**Yes**	**No**
1. Has a doctor ever denied or restricted your participation in school or work for any reason?	__	__
2. Do you have an ongoing medical condition (like diabetes or asthma)?	__	__
3. Are you currently taking any prescription or nonprescription medicines or pills?	__	__
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	__	__
5. Have you ever passed out or nearly passed out during exercise?	__	__
6. Have you ever passed out or nearly passed out after exercise?	__	__
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	__	__
8. Does your heart race or skip beats during exercise?	__	__
9. Has a doctor ever told you that you have (check all that apply): __ High blood pressure __ a heart murmur __ High cholesterol __ a heart infection		
10. Has a doctor ever ordered a test for your heart? (EKG, echocardiogram)	__	__
11. Has anyone in your family died for no apparent reason?	__	__
12. Does anyone in your family have a heart problem?	__	__
13. Has any family member or relative died of heart problems or of sudden death before age 50?	__	__
14. Does anyone in your family have Marfan syndrome?	__	__
15. Have you ever spent the night in the hospital?	__	__
16. Have you ever had surgery?	__	__
17. Have you ever had an injury (sprain, muscle tear, tendonitis) that caused you to miss practice or a game? If yes, circle below:	__	__
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	__	__
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, brace, cast, or crutches? If yes, circle below:	__	__
Head Neck Shoulder Arm Elbow Forearm Hand/Fingers		
Chest Back Hip Thigh Knee Calf/Shin Ankle Foot/toes		
20. Have you ever had a stress fracture?	__	__
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	__	__
22. Do you regularly use a brace or assistive device?	__	__
23. Has a doctor ever told you that you have asthma or allergies?	__	__

	Yes	**No**
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	__	__
25. Is there anyone in your family with asthma?	__	__
26. Have you ever used an inhaler or taken asthma medication?	__	__
27. Were you born without or are you missing a kidney, eye, testicle or any other organ?	__	__
28. Have you had infectious mononucleosis (mono)?	__	__
29. Do you have any rashes, pressure sores, or other skin problems?	__	__
30. Have you had a herpes skin infection?	__	__
31. Have you ever had a head injury or concussion?	__	__
32. Have you been hit in the head and been confused or lost your memory?	__	__
33. Have you ever had a seizure?	__	__
34. Do you have headaches with exercise?	__	__
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	__	__
36. Have you ever been unable to move your arms or legs after being hit or falling?	__	__
37. When exercising in the heat, do you have severe muscle cramps or become ill?	__	__
38. Has a doctor told you that you or someone in your family has sickle cell trait or disease?	__	__
39. Have you had any problems with your eyes or vision?	__	__
40. Do you wear contact lenses or glasses?	__	__
41. Do you wear protective eyewear (goggles, face shield)?	__	__
42. Are you happy with your weight?	__	__
43. Are you trying to lose or gain weight?	__	__
44. Has anyone recommended you change weight or eating habits?	__	__
46. Do you have any concerns you would like to discuss?	__	__

FEMALES ONLY

47. Have you ever had a menstrual period?	__	__

48. How old were you when you had your first menstrual period? _____
49. 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 Student _____ Signature of parent/guardian_____ Date _____

Medical Evaluation **PHYSICAL EXAMINATION FORM**

Name _____ **Date of Birth**_____

Height _____ **Weight**_____ **BP**_____

Vision: R 20/____ L 20/___ Corrected: Y N Pupils: Equal Unequal

Tobacco Use? Y N _____ **Alcohol use? Y N** _____ **Supplements? Y N** _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
HEENT			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
GU			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Medical Evaluation **CLEARANCE FORM**

Name_____**Date of birth**_____

EMERGENCY INFORMATION
Allergies_____Medications_____
Medical Conditions_____
Insurance_____Policy Number_____

Name of Physician_____Date_____

Address_____Phone_____

Signature_____