2014– 2015 ATHLETIC MEDICAL EVALUATION FORM

Personal History

Name _____ Sex _____ Age _____ DOB _____

Grade _____ Sport _____ School _____

Personal Physician _____ Telephone _____

Address _____

1. Have you ever had a pre-participation physical before?..... ☐ Yes ☐ No

   Have you ever had surgery?..... ☐ Yes ☐ No

2. Are you presently taking any medications or pills?..... ☐ Yes ☐ No

3. Do you have any allergies (medicine, bees or other stinging insects)?..... ☐ Yes ☐ No

4. Have you ever passed out during exercise?..... ☐ Yes ☐ No

   Have you ever been dizzy during or after exercise?..... ☐ Yes ☐ No

   Have you ever had chest pain during or after exercise?..... ☐ Yes ☐ No

   Do you tire more quickly than your friends during exercise?..... ☐ Yes ☐ No

   Have you ever had high blood pressure?..... ☐ Yes ☐ No

   Have you ever been told that you have a heart murmur?..... ☐ Yes ☐ No

   Have you ever had a racing of your heart or skipped heartbeats?..... ☐ Yes ☐ No

   Has anyone in your family died of heart problems or a sudden death before age 50?..... ☐ Yes ☐ No

5. Do you have any skin problems (itching, rashes, acne) ?..... ☐ Yes ☐ No

6. Have you ever had a head injury?..... ☐ Yes ☐ No

   Have you ever been knocked unconscious?..... ☐ Yes ☐ No

   Have you ever had a seizure?..... ☐ Yes ☐ No

   Have you ever had a stinger, burner, or a pinched nerve?..... ☐ Yes ☐ No

7. Have you ever had heat or muscle cramps?..... ☐ Yes ☐ No

   Have you ever been dizzy or passed out in the heat?..... ☐ Yes ☐ No

8. Do you have trouble breathing or do you cough during or after activities?..... ☐ Yes ☐ No

9. Do you use any special equipment (pads, braces, neck roll, mouth guard, eye guard) ?..... ☐ Yes ☐ No

10. Have you had any problems with your eyes or vision?..... ☐ Yes ☐ No

    Do you wear glasses or protective eye wear?..... ☐ Yes ☐ No

11. Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling of any bones or joints?

    ☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest

    ☐ Forearm ☐ Shin/Calf ☐ Foot ☐ Back ☐ Wrist/Hand ☐ Ankle ☐ Hip

12. Have you ever had any other specific medical problems (infectious mononucleosis, diabetes) ?..... ☐ Yes ☐ No

13. Have you had a medical problem since your last evaluation?..... ☐ Yes ☐ No

14. When was you last tetanus shot? _____

When was your last measles shot? _____

15. When was your first menstrual period? _____

When was you last menstrual period? _____

When was the longest time between your periods last year? _____

Please explain "yes" Answers here:

_____

_____

_____

_____

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

_____

Signature of Athlete Signature of Parent/Guardian Date

The remainder of this form is to be completed and approved by your physician.

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20/ _____ L20/ _____ Corrected? ☐ Yes ☐ No Pupils _____

Ears, Nose, Throat _____

Heart _____

Chest / Lungs _____

Skin / Lymphatics _____

Abdominals _____

Genitalia / Hernia _____

Musculoskeletal Examination Examiner _____

Neck / Back _____

Upper Extremities _____

Lower Extremities _____

Flexibility _____

Official Recommendation

A. This athlete ☐ may ☐ may not compete in athletics based on the data gathered from this exam.

B. Prior to participation, treatment or follow-up on the following is recommended:

_____

C. Recommend further consultation with: _____

Signature of Physician _____ Date _____