HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam	a an			
Name			and a stand of the stand of t	Date of birth
Sex	Age	Grade	School	Sport(s)
Medicines an	d Allergies: Please	list all of the pr	escription and over-the-counter med	icines and supplements (herbal and nutritional) that you are currently taking
Do you have a	ny allergies? D	Yes 🗆 No	If yes, please identify specific allerg	y below.

Stinging Insects

Do you have any allergies?	🗆 Yes	□ No If yes, □ Pollens	please identify specifi	c allergy below
Explain "Yes" answers below. (Sircle questio	ons you don't k	now the answers to.	

		A			
GENERAL QUESTIONS	Yes	Ne	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			27. Have you ever used an inhaler or taken asthma medicine?		
below: 🛛 Asthma 🔲 Anemia 🔲 Diabetes 🔲 Infections			28. Is there anyone in your family who has asthma?		
Other: 3. Have you ever spent the night in the hospital?	<u> </u>	<u> </u>	29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spieen, or any other organ?		
4. Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?		
KEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
5. Have you ever passed out or nearly passed out DURING or	1603	1455	32. Do you have any rashes, pressure sores, or other skin problems?		
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?		
6. Have you ever had discomfort, pain, tightness, or pressure in your			34. Have you ever had a head injury or concussion?		
chest during exercise?			35. Have you ever had a hit or blow to the head that caused confusion,		 .
7. Does your heart ever race or skip beats (oregular beats) during exercise?			prolonged headache, or memory problems?		
Has a doctor ever told you that you have any heart problems? If so, about all that applies			36. Do you have a history of seizure disorder?	1	
check all that apply:			37. Do you have headaches with exercise?		
High cholesterol Hawasaki disease Other:	1 months man		38. Have you ever had numbriess, tingling, or weakness in your arms or legs after being hit or falling?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiouram)			39. Have you ever been unable to move your arms or legs after being hit or falling?		
10. Do you get lightheaded or feel more short of breath than expected		1	40. Have you ever become ill while exercising in the heat?	t	
during exercise?			41. Do you get frequent moscle cramps when exercising?	1	
11. Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?	1	
12. Do you get more tired or short of breath more quickly than your friends			43. Have you had any problems with your eyes or vision?		
during exercise?		<u> </u>	44. Have you had any eye injuries?		
NEART NEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?		
 Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including) 			46. Do you wear protective eyewear, such as goggles or a face shield?		
drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		
 Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, anthythmogenic right ventricolar cardiomyopathy, long QT 			48. Are you trying to or has anyone recommended that you gain or lose weight?		
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of foods?	1	
15. Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?		
implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
seizures, or near drowning?		Ì	52. Have you ever had a menstrual period?		
BONE AND JOINT QUESTIONS	Yes	Ne	53. How old were you when you had your first menstrual period?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendor that caused you to miss a practice or a game?			54. How many periods have you had in the last 12 months?		
18. Have you ever had any broken or fractured bones or dislocated joints?			Explain "yes" answers here		
 Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? 					
20. Have you ever had a stress fracture?					
 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) 					
22. Do you regularly use a brace, ortholics, or other assistive device?			·		
23. Do you have a bone, muscle, or joint injury that bothers you?		1		-	
24. Do any of your joints become painful, sweller, feel warm, or look red?					
25. Do you have any history of invenile arthritis or connective tissue disease?					

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

© 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

Date

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Balance Date of birth Str. Age Grade School Spoort(s) 1. Type of disability	Date of Exa	am					
1. Type of disability 2. Data of disability 2. Data of disability 4. Casce of disability (bith. disease, academit/inserve, atber) 5. Last the sports you as interediat in playing 6. Do you are sport are the sports where and playing 7. Do you as any sportal than co reactive devices, or prosthetic? 8. Do you have any retables, pressure asses, or any other skin problems? 9. Do you are any sportal than co reactive devices or prosthetic? 10. Do you are any sportal diverse or active devices or prosthetic? 11. Do you are any sportal than co reactive devices or prosthetic? 12. Do you are any sportal diverse or active diverse devices or prosthetic? 13. Do you are any sportal diverse or active diverse devices or both active diverse div	Name		and a second		Date of birth	And the state of the	
2. Data of skability 3. Cassification (if available) 4. Casse of clashify [kith: disesse, accident/trame, other) 5. List the sports you are intersected in polyring 7. Do you are any special threat or assifted device, or presthetic? 7. Do you are any special threat or assifted device for polyrin? 8. Do you have a brasing loss? 9. Do you have a vecked, mean or assifted device for polyrin? 9. Do you have a vecked, mean or assifted device for polyrin? 10. Do you have a vecked inspection? 11. Do you have a vecked inspection? 12. Bayou have bareing loss? 13. Da you have a vecked inspection? 14. Inspection and automic dynetice? 15. Do you have a based spection? 15. Do you have a based spection? 15. Do you have a base devices for howed or blacked function? 15. Do you have any asset spection? 16. Do you have any device based spection? 17. Da you have any device based spection? 18. Do you have any device based spection? 19. Do you have any device based spection? 10. Do you have any device	Sex	Age	Grade	School	Sport(s)		
1. Classification (if evaluable) 4. Class of disatify girth. (lasses, acident/trains, other) 5. Last the sports you se intersected in ploying 7. De you use any special basic or assistive device, or presthetic? 7. De you use any special basic or assistive device for sports? 8. De you have any special basic or assistive device for sports? 9. De you have a weight plose Down, assistive device for sports? 9. De you have a weight plose Down, assistive device for sports? 10. De you have a visual imposition of discontify the uniteding? 11. De you have a visual imposition of discontify the uniteding? 12. A you have a visual imposition of discontify the uniteding? 13. Navy unit and autonomic de discontify the function? 14. Ken you are weight glose? 15. De you have a weight specify Down and a bladder function? 16. De you have a weight specify Down and the controlled by matication? 17. De you have a match specify and the controlled by matication? 18. De you have a weight specify Down and the controlled by matication? 19. De you have a way of the following. 4. A distant function if the uniteding? 19. De you have a way of the following. 4. A distant function if the uniteding? 19. De you have a way of the following. 4. A distant function if the uniteding?	1. Type o	f disability					
4. Cause of disability (bith. disease, excident/liceure, other) 5. List the sports you is interstead in helping 5. List the sports you is interstead in helping 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Proy cause any sportal thrace or assisted educe for prosthelic? 7. Prove thrace and subtrease for prosthelic? 7. Prove thrace and subtrease for prosthelic? 7. Prove thrace and thrace integrate integrate educe for prosthelic? 7. Prove thrace and thrace for prosthelic? 7. Prove thrace and thrace integrate for prosthelic? 7. Prove thrace and thrace integrate educe for prosthelic? 7. Prove thrace and thrace and of the following. 7. Prove thrace and thrace integrate educe for prosthelic? 7. Prove thrace and thrace integrate educe for prosthelic? 7. Prove thrace and thrace integrate educe for prosthelic? 7. Prove thrace and thrace integrate educe for prosthelic? 7. Prove thrace and thrace integrate educe for prosthelic? 7. Prove thrace and thrace and the following. 7. Prove thrace and thrace educe for prosthelic? 7. Prove thrace and thrace educe for prosthelic? 7. Prove thrace educe for prosthelic? 7. Prove thrace educe for prosthelic?	2. Date o	f disability					
5. List the sports you are interested in playing Yes No 6. Do you regularly use a brace, assistive device, or presthelle?	3. Classif	fication (if available)					
Yes No 6. Do you readerly use a brace, assistive device, or prosthetic?	4. Cause	of disability (birth, di	sease, accident/trauma, other)				
8. Do you regularly use a brace, assistive device, or prostRelic?	5. List th	e sports you are inter	ested in playing				
1. Do you use any special brace or assistive device for sports?						Yes	No
B. Do you have any rashes, pressure sores, or any other skin problems? S. Du you have a hearing lass? Do you use a hearing lad? D. Do you have a weak ling lammen? S. Du you have burning or disconfield when undering? S. Have you fauld autonomic dysertexitie? S. Have you fauld autonomic dysertexitie? S. Du you have burning or disconfield when undering? S. Du you have burning or disconfield when undering? S. Have you fauld autonomic dysertexitie? S. Du you have muscle spacetory? S. Du you have ever had any of the following. September of antidoxid instability September of a stable provide the following. September of automatic spacetory of the following. September of a stable provide the following. Septem	6. Do you	u regularly use a brac	e, assistive device, or prostheti	;?			
9. Du you have a heating loss? Do you use a heating aid? Image: Comparison of the set							
10. Do you have a visual impairment? III. Do you use any special divices for howel or bladder function? 11. Do you use any special divices for howel or bladder function? III. 12. O you have burning or discontrol when utrateding? III. 13. Have you were basen dispraced with a heat-related (hypothermia) or cold-related (hypothermia) illness? III. 14. Have you were basen dispraced with a heat-related (hypothermia) iffees? III. 15. Do you have mackle gasticity? IIII. 16. Do you have mackle gasticity? IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII				problems?			
11. Do you use any special devices for bowel or bladder function?							
12. Do you have burning or discontfort when urinsting?							ļ
13. Have you had autonomic dystellexite?				on?			
14. Have you ever been disgnosed with a heat-related (hypothermia) itines? 15. Do you have muscle speaktory? 15. Do you have muscle speaktory? 16. Do you have frequent soizures that cannot be controlled by medication? Explain "yes" answers here 14. Have you have ever had any of the following. Please indicate if you have ever had any of the following. Yes No Mantoaxial instability X-ray evaluation for attantoaxial instability Yes Dislocated joints (more than one) Easy bleeding Easy bleeding 14. East one one) Easy bleeding 14. East one one one one one							<u> </u>
15. Do you have muscle spasticity? III. Do you have frequent seizures that cannot be controlled by medication? Explain "yes" answers here III. Do you have reacting the controlled by medication? Explain "yes" answers here III. Do you have ever hed any of the following. Please indicate if you have ever hed any of the following. Yes No Atlantoxial instability X-ray evaluation for atlantoxial instability III. Dislocated justs (more than one) Easy bleeding IIII. Dislocated is a stability Ubicated of oxteoporosis IIII. Dislocated is bleeding Iterating at goteen IIII. Dislocated is bleeding Hepatitis IIIII. Dislocated is bleeding Ubificulty controlling based IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII							
16. Do you have frequent seizures that cannot be controlled by medication? Explain "yes" answers here Please indicate if you have ever had any of the following. Yes No Attantoxidal instability X-ray evaluation for attantoxida instability Dislocated joints (more than one) Easy bleeting Endarged spleen Hepatibis Ostopprovide Difficulty controlling bladder Difficulty controlling bladder Numbness or tingling in arms or hands Weakness in arms or hands Weakness in arms or hands Weakness in arms or hands Spine biffida				termia) or cold-related (hypothermia) illi	1888?		
Explain "yes" answers here Please indicate if you have ever had any of the following. Please indicate if you have ever had any of the following. Attantoaxial instability X-ray evaluation for attantoaxial instability X-ray evaluation for attantoaxial instability Easy bleeding Endarged spleen Hepatits Geteopering or osteoperosis Difficulty controlling bladder Numbness or tingling in terms or bends Numbness or tingling in terms or feet Weakness in terms or hands Weakness in tegs or feet Recent change in coordination Easy to walk Spina bliftad							
Please indicate if you have ever had any of the following. Yes No Attantoaxial instability	16. Do you	u have frequent seizu	res that cannot be controlled by	/ medication?			1
Yes No Atlantoaxial instability							
Yes No Atlantoaxial instability							
Attantoaxial instability	Please ind	icate if you have ev	er had any of the following.				New York and the South of Market South of Southof of South of South of South of South of Sout
X-ray evaluation for attantoaxial instability						Yes	No
Dislocated joints (more than one)				** -**			
Easy bleeding Image of the spleen Hepatitis Image of the spleed of the sple							
Enlarged spleen	£		e)				
Hepatitis							
Osteopenia or osteoporosis Image: Constraint of the second se		5416631					
Difficulty controlling bladder		a or octoororie					
Difficulty controlling bladder							
Numbness or tingling in arms or hands							
Numbness or tingling in legs or feet			er hands				
Weakness in arms or hands				an sa a sa ana ang ang ang ang ang ang ang ang an			
Weakness in legs or feet							
Recent change in coordination				andaran managana ang sa ang			
Recent change in ability to walk Spina bifida			Se nya yakana yakana yakana yakana kata waka ka wakana kata ya Ayan yang bayina kata yak				
Spina bifida			<				
Latex allergy	Spina bifid	la					1
	Latex aller	бу					

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

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

PHYSICAL EXAMINATION FORM

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

		And the second s	
Height Weight 🛛 Male	E 🛛 Female		
BP / (/) Pulse Vision	n R 20/	L 20/	Corrected 🗆 Y 🗆 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		nou-i-e-e-e-e-e-e-e-e-e-e-e-e-e-e-e-e-e-e-	
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back	1		
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional Duck-walk, single leg hop			
* Dock votat, single-reg rop *Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. *Consider GU exam if in private setting. Having third party present is recommended		1	

"Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Cleared for all sports without restriction

Cleared for all sp	ports without restriction with recommendations for further evaluation or treatment for
Not cleared	
D Pe	anding further evaluation
	or any sports
CI Fo	or certain sports
Re	eason
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 physical may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type)	Date	
Address Phone		
Signature of physician		. MD or DO

© 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment. HE0503

CLEARANCE FORM

Name	Sex 🗆 M 🗆 F Age	Date of birth	
□ Cleared for all sports without restriction			
□ Cleared for all sports without restriction with recommen	dations 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 contraindications to practice and particip and can be made available to the school at the re the physician may rescind the clearance until the (and parents/guardians).	pate in the sport(s) as outlined above. A copy of equest of the parents. If conditions arise after t	f the physical exam is on record in m he athlete has been cleared for partic	y office cipation,
Name of physician (print/type)		Date	
Address		Phone	
Signature of physician			, MD or DO
EMERGENCY INFORMATION			
Allergies			
Other information			
-			

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.