CREAN LUTHERAN HIGH SCHOOL

HISTORY FORM

DATE OF EXAM: _____

PRE-PARTICIPATION PHYSICAL EVALUATION

Name: _____ Sex: _____ Age: _____ Date of birth: _____

Grade: _____ School: _____ Sport(s): _____

Address: _____ Phone: _____

Personal Physician: _____

In case of emergency, contact: Name: _____ Relationship: _____

Phone (*Home*): _____ Phone (*Work*): _____

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

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (*like diabetes or asthma*)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (*over-the-counter*) 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? (*for example: ECG, 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 a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area 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, a brace, a cast, or crutches? If yes, circle below:	☐	☐
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?	☐	☐

Head Neck Shoulder Upper Arm Elbow Forearm Hand/ Fingers Chest

Upper Back Lower Back Hip Thigh Knee Calf/ Shin Ankle Foot/Toes

		Yes	No
24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
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 sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you happy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

		Yes	No
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 Athlete: _____ Signature of Parent/Guardian: _____ Date: _____

Behold, I will bring to it health and healing, and I will heal them and reveal to them abundance of prosperity and security. Jeremiah 33:6

CREAN LUTHERAN HIGH SCHOOL

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

Height: _____ Weight: _____ % Body Fat (*optional*): _____ Pulse: _____ BP: ____ / ____ (____ / ____ , ____ /____)

Vision: Right 20/_____ Left 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes / Ears / Nose / Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (*males only*)+			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand / Fingers			
Hip/Thigh			
Knee			
Leg / Ankle			
Foot / Toes			

**Multiple-examiner set-up only.*
+Having a third party present is recommended for the genitourinary examination.

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

☐ Not Cleared for: _____ Reason: _____

Recommendations: _____

_____

_____

NAME OF PHYSICIAN: _____ DATE: _____

ADDRESS: _____ PHONE: _____

SIGNATURE OF PHYSICIAN: _____, MD OR DO

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