

**THIS QUESTIONNAIRE IS FOR PATIENT'S MEDICAL RECORD ONLY DO NOT RETURN TO SCHOOL  
PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT**

**SPORTS PHYSICAL PHYSICIAN OFFICE FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Student ID: \_\_\_\_\_  
 Sports: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_ Male  Female

**EXPLAIN YES ANSWERS BELOW CIRCLE QUESTIONS YOU DO NOT UNDERSTAND**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a medical condition (asthma/diabetes)?                   | <input type="checkbox"/> | <input type="checkbox"/> |

**CARDIAC RISK:**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Has any relative died of a heart condition suddenly before age 50?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you or your relatives have a history of:  |                          |                          |
| a. Heart muscle disease such as hypertrophic cardiomyopathy?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arrhythmia, irregular rhythm, pacemaker WPW (Wolf Parkinson White), Long QT syndrome or other cardiac problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Marfan Syndrome?   | <input type="checkbox"/> | <input type="checkbox"/> |

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 3. Does your heart race or skip beats during exercise?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had chest pain during exercise?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out during or after exercise?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a history of high blood pressure?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of a heart murmur (other than innocent murmur) or other heart problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of unexplained dizziness with exercise?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had an ECG or Echocardiogram test for your heart?                | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. History of congenital heart disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. History of Carditis or Kawasaki disease?                                      | <input type="checkbox"/> | <input type="checkbox"/> |

**RESPIRATORY RISK:**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. History of cough, wheezing, or difficulty breathing during or after exercise?              | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever used an inhaler or taken asthma medication?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a history of severe allergies to pollens, stinging insects, foods, or grasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been told by a doctor that you have asthma?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. History of fractured ribs in the last 6 weeks?   | <input type="checkbox"/> | <input type="checkbox"/> |

**NEUROLOGICAL RISK:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. History of head or neck injury, or concussion?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had amnesia or memory loss after a head injury?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of seizures?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. History of headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a history of any problems with your eyes or vision?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you wear glasses or contact lenses?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of neck instability (i.e. Atlantoaxial Instability)   | <input type="checkbox"/> | <input type="checkbox"/> |

**INFECTION RISK:**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do you have a history of recurrent or persistent rashes, pressure sores, herpes, or other skin infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed or treated for a MRSA infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. History of Mono (EBV) in the last 4 weeks?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of recurrent unexplained fevers, or chronic coughing?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you or any members of your household have a history of tuberculosis or positive PPD?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. History of Hepatitis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of HIV?  | <input type="checkbox"/> | <input type="checkbox"/> |

**ORTHOPEDIC RISK:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Have you ever broken any bones?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. History of neck or back injury?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. History of chronic back or neck pain?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of ankle, knee, hip injury?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. History of wrist, elbow, shoulder injury?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any artificial limbs or prosthetic devices (false teeth)? | <input type="checkbox"/> | <input type="checkbox"/> |

**OTHER PERTINENT QUESTIONS:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Are you taking any prescription or nonprescription (over the counter) medicines or pills?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you taking supplements or medications to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking medications or supplements to increase your strength or improve your sports performance?       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you trying to gain or lose weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Were you born without or are you missing a kidney, eye, (if male testicle), (if female ovary) or other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. History of bleeding or clotting disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of severe muscle cramps or feeling severely ill when exercising in the heat?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. History of enlarged liver or spleen?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. History of sickle cell disease/trait?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. History of Hypoglycemia (low blood sugar)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Any medical changes since your last physical?  | <input type="checkbox"/> | <input type="checkbox"/> |

**FEMALES OLDER THAN 16 (OPTIONAL):**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Have you had no periods?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you gone more than 90 days without a period in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |

**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: \_\_\_\_\_

## SPORTS PHYSICAL SCHOOL FORM

I grant permission to release the information below to School Personnel.

Signature of Parent/Guardian: \_\_\_\_\_

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Student ID: \_\_\_\_\_  
 Sports: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 ALLERGIES: \_\_\_\_\_ MEDICATIONS: \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_

HEARING:  Passed Right/Left <25dcbis (all frequencies)      Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Both 20/\_\_\_\_ Corrected:  Y  N  
 Failed \_\_\_\_\_  Not Done      U/A:  Normal \_\_\_\_\_

REQUIRED IMMUNIZATIONS: Measles, Mumps, Rubella, Hepatitis B, Polio, Tetanus, Pertussis, and Varicella/illness.

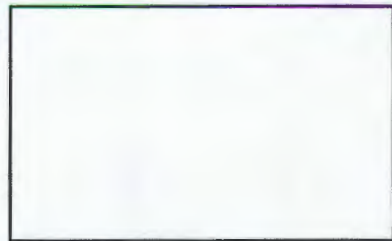
Up to date (See Attached Vaccine Documentation)       Not up to date, Vaccines Needed: \_\_\_\_\_  
 Baseline Concussion Assessment

MEDICAL:	NORMAL	ABNORMAL FINDINGS
General Appearance		
Head eyes/ears/nose/throat		
Neck		
Respiratory		
Heart		
Pulses		
Abdomen		
Skin		
Neuro		
Lymph Nodes		
Genitourinary (males only)		

MUSCULOSKELETAL:	NORMAL	ABNORMAL FINDINGS
Back (including scoliosis screen)		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

Assessment/Plan: \_\_\_\_\_

OFFICE STAMP:



Cleared for all sports without restrictions  
 Not Cleared for:  All sports    Certain sports: \_\_\_\_\_  
 Reason: \_\_\_\_\_

Deferred requires further evaluation (See Recommendations Below):  
 Cleared with restrictions (See Recommendations Below):

Recommendations: \_\_\_\_\_

Name of Physician (print): \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_, M.D., D.O., or N.P. Date: \_\_\_\_\_