

# PHYSICAL EXAM/ EVALUATION FORM



ST. PIUS X HIGH SCHOOL  
Dominican Sisters of Houston • 1956

**STUDENT NAME:** \_\_\_\_\_

GENDER: \_\_\_\_\_ AGE: \_\_\_\_\_ GRADE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ % OF BODY FAT OR BMI (if calculated): \_\_\_\_\_

PULSE: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_

**\*\*VISION:** R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ CORRECTED: No \_\_\_\_\_ Contacts \_\_\_\_\_ Glasses \_\_\_\_\_ PUPILS: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

**\*\*HEARING SCREENING:** R \_\_\_\_\_ / L \_\_\_\_\_ PASS FAIL Hearing Aids: Y / N (\*\*required for freshman and transfers\*\*)

**\*\*SCOLIOSIS SCREENING:** Negative / Positive Back Brace: Y / N (\*\*required for freshman and transfers\*\*)

**\*\*All three screenings above are required for freshmen and transfers. Vision is completed yearly for physicals\*\***

| Medical                                                   | Normal | Abnormal Findings | Initials * |
|-----------------------------------------------------------|--------|-------------------|------------|
| Appearance                                                |        |                   |            |
| Eyes/Ears/Nose/Throat                                     |        |                   |            |
| Lymph Nodes                                               |        |                   |            |
| Heart- Auscultation of the Heart in the supine position   |        |                   |            |
| Heart- Auscultation of the Heart in the standing position |        |                   |            |
| Heart- Lower extremity pulses                             |        |                   |            |
| Pulses                                                    |        |                   |            |
| Lungs                                                     |        |                   |            |
| Abdomen                                                   |        |                   |            |
| Genitalia (males only)                                    |        |                   |            |
| Skin                                                      |        |                   |            |

| Musculoskeletal | Normal | Abnormal Findings | Initials * |
|-----------------|--------|-------------------|------------|
| Neck            |        |                   |            |
| Back/Spine      |        |                   |            |
| Shoulder/Arm    |        |                   |            |
| Elbow/Forearm   |        |                   |            |
| Wrist/Hand      |        |                   |            |
| Hip/Thigh       |        |                   |            |
| Knee            |        |                   |            |
| Lower Leg/Ankle |        |                   |            |
| Foot            |        |                   |            |

\*station based exam only

## Clearance

☐ Cleared

☐ Cleared after completing evaluation/rehab for: \_\_\_\_\_

Activity Not Cleared for: \_\_\_\_\_

Reason's/ Recommendations: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date of Examination: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

## MEDICAL HISTORY FORM

This Medical History Form must be completed annually by the parent (or guardian) and student before the beginning of each school year. These questions are designed to assist the practitioner in determining if the student has developed any condition which would make it hazardous to participate in an extracurricular activity.

**STUDENT NAME:** \_\_\_\_\_ **GRADE LEVEL:** 9 10 11 12  
**GENDER:** Male / Female **AGE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**HOME ADDRESS:** \_\_\_\_\_ **CONTACT PHONE #:** (\_\_\_\_) \_\_\_\_-\_\_\_\_\_  
**PERSONAL PHYSICIAN:** \_\_\_\_\_ **PHYSICIAN PHONE #:** (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

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If the answer to any question is yes, please discuss the circumstances with your provider at the time of the physical examination.

|                                                                                                                                                                                                                                                 | YES                      | NO                       | UNKNOWN                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Have you had a medical illness or injury since your last physical?                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been hospitalized overnight in the past year?                                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery?                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had prior testing ordered by a physician?                                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever passed out during or after exercise?                                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pains during or after exercise?                                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends during exercise?                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had your racing of your heart?                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have your ever had your heart skip beats?                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been diagnosed with high blood pressure?                                                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been diagnosed with high cholesterol?                                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been diagnosed with a heart murmur?                                                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any member of your biological family died of heart problems or sudden unexplained death prior to the age of 50?                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any biological family member been diagnosed with an enlarged heart (dilated Cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome, or other ion Channelopathy (Brugada Syndrome, etc), Marfan's Syndrome or abnormal heart rhythm? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (such as myocarditis or mononucleosis) within the last month?                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## MEDICAL HISTORY FORM

|                                                                                                                            | YES                      | NO                       | UNKNOWN                  |
|----------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Has a physician ever denied or restricted your participation in extracurricular activities for any heart related problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a diagnosed head injury or concussion?                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious or lost memories?                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes to the question above, how many times? _____                                                                        |                          |                          |                          |
| If yes, when was your last diagnosed concussion? ____/____/____                                                            |                          |                          |                          |
| If Yes, how severe were each of the concussions? Discuss with the Provider                                                 |                          |                          |                          |
| Have you ever had a seizure?                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches?                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands legs or feet?                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve?                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been dizzy during or after exercise?                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been ill from exercising in the heat?                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had problems with your eyes or vision?                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been unexpectedly short of breath while exercising?                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been diagnosed by a physician with asthma?                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies which require medical attention or treatment?                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you missing any paired organs?                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you presently under a doctor's care for any condition?                                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently taking any prescription or nonprescription medication?                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you presently using an inhaler, prescribed or nonprescribed?                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any known allergies (pollen, medicine, food or insects)?                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have current skin problems (examples: itching, rashes, acne, warts, blisters or fungus)?                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you want to weigh more or less than you do today?                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel stressed out?                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been diagnosed with or treated by a physician for sickle cell trait or sickle cell disease?                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## MEDICAL HISTORY FORM

YES NO UNKNOWN

Do you use any special protective or corrective equipment that are not usually used for your particular activities (examples: knee brace, neck roll, foot orthotics, retainer, prescription goggles or hearing aid)?

☐ ☐ ☐

Have you ever had swelling after a sprain, strain or injury?

☐ ☐ ☐

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YES NO UNKNOWN

Have you ever broken or fractured any bones or dislocated any joints?

☐ ☐ ☐

Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, please check each box below that applies.

|           |                          |         |                          |             |                          |
|-----------|--------------------------|---------|--------------------------|-------------|--------------------------|
| HEAD      | <input type="checkbox"/> | ELBOW   | <input type="checkbox"/> | HIP         | <input type="checkbox"/> |
| NECK      | <input type="checkbox"/> | FOREARM | <input type="checkbox"/> | THIGH       | <input type="checkbox"/> |
| BACK      | <input type="checkbox"/> | WRIST   | <input type="checkbox"/> | KNEE        | <input type="checkbox"/> |
| CHEST     | <input type="checkbox"/> | HAND    | <input type="checkbox"/> | SHIN / CALF | <input type="checkbox"/> |
| SHOULDER  | <input type="checkbox"/> | FINGER  | <input type="checkbox"/> | ANKLE       | <input type="checkbox"/> |
| UPPER ARM | <input type="checkbox"/> | FOOT    | <input type="checkbox"/> |             |                          |

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**Female Students Only** (If left blank I agree to provide such information to the provider at the time of examination)

When was your first menstrual period? \_\_\_/\_\_\_

When was your most recent menstrual period? \_\_\_/\_\_\_

How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_ days

What was the longest time between periods in the last year? \_\_\_\_\_ days

How many periods have you had in the last year?

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**Male Students Only** (If left blank I agree to provide such information to the provider at the time of examination)

Are you missing a testicle? YES NO

Do you have any testicular pain? YES NO

Do you have any testicular swelling or masses? YES NO

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## MEDICAL HISTORY FORM

I hereby state that to the best of my knowledge, my answers to the questions asked on this form are complete and correct. I understand that failure to provide truthful and complete responses could subject the student to non-participation at school events.

Student Full Name: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent / Guardian Name: \_\_\_\_\_

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

Date of Signature: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please Print in Box**

School: St. Pius X High School

Student Name: \_\_\_\_\_

**Confirmation of Understanding of Limited Scope and Purpose of the  
Extra-Curricular/Co-Curricular Pre-Participation Physical Exams**

I, \_\_\_\_\_, (Print Parent/Legal Guardian Name) am aware that my child/ward,  
\_\_\_\_\_ (Print Child's Name), will attend an event providing pre-participation physical exams for  
student athletes at St. Pius X on May, 18, 20 26 ("the event"). The event is sponsored and provided by  
Houston Methodist ("Houston Methodist") for the sole purpose of clearing students for participation in extra-curricular/co-  
curricular programs. The screening physical exam will be performed by volunteer healthcare providers. By signing this form, I  
am confirming I understand and agree to the following:

- **I consent to the extra-curricular/co-curricular physical exam for the above-named child.**
- This is **NOT** a comprehensive physical exam and should not take the place of routine medical care; I understand that this is a **screening physical for clearance for participation in extra-curricular/co-curricular activities ONLY**;
- Any patient-physician relationship created during the event will terminate immediately upon completion of the screening physical;
- I understand that my child may need additional testing before he/she can be cleared for participation in athletic activities and it is my sole responsibility to obtain such additional testing or medical care; I understand that if it is determined that my child needs additional medical treatment; I will be notified of any such recommendation. I understand that a limited number of non-invasive tests may be available and performed at the event for my convenience; **I consent to any and all additional non-invasive testing as deemed necessary by the screening physician during the event without notification to me prior to the testing**;
- I consent to the release of the results of my child's physical screening exam to his or her school (including a coach, athletic trainer, teacher or administrator) present at the event. This consent is valid for 180 days and I understand that I may revoke this consent at any time. I understand that the information released may not be protected under the law once it is disclosed and may be subject to re-disclosure by the Recipient.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

**RELEASE FROM LIABILITY AND INDEMNIFICATION**

I hereby release, waive, discharge and covenant not to sue Houston Methodist and its subsidiaries, officers, directors, trustees, employees, agents and affiliated companies from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be caused by or related to my child's participation or presence at the extra-curricular/co-curricular Physical Examination Event.

I acknowledge that I have read and understand the foregoing Release and that my signature below acknowledges the statements made in the Release.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

Print Name: \_\_\_\_\_



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