HISTORY FORM

***Form completed annually prior to your Physical. Athlete and parent should fill out form prior to visit.** – **Form stays with Primary Care Practitioner (PCP) Office.**

Name: ______ Gender: ______ Date of Birth: ______ Age: ______
Grade: ______ School: ______ Sports(s): ______

List past and current medical conditions: ______
Have you ever had surgery? If yes, list all past surgical procedures: ______
List all current prescriptions, OTC medicines, & herbal/nutritional supplements: ______
List all of your allergies (medicines, pollens, food, stinging insects, etc.): ______

Over the past 2 weeks, how often have you been bothered by any of the following (check):

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	______ 0	______ 1	______ 2	______ 3
Not being able to stop or control worrying	______ 0	______ 1	______ 2	______ 3
Little interest or pleasure in doing things	______ 0	______ 1	______ 2	______ 3
Feeling down, depressed, or hopeless	______ 0	______ 1	______ 2	______ 3

***Mental Health: A sum of >/= 3 for questions 1+2, or 3+4, is considered positive

**** **Answer YES if it EVER occurred.**

GENERAL QUESTIONS	YES	NO
1. Do you have any concerns you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU		
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, *or* skip beats (irregular beats) during exercise?		
7. Has a doctor told you that you have any heart issues?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiogram (EKG) or echocardiogram?		
9. Do you get lightheaded or feel shorter of breath more than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker, or implanted defibrillator before age 35?		
BONE AND JOINT QUESTIONS		
14. Since you were last cleared to play sports, have you had a new injury to a bone, muscle, ligament or tendon?		

MEDICAL QUESTIONS	YES	NO
15. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
16. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
17. Do you have groin, testicle pain, or a painful bulge or hernia in the groin area?		
18. Do you have any recurring skin rashes or rashes that come and go including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
19. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problem?		
20. Have you ever had numbness, tingling, weakness in your arms or leg or been unable to move your arms or legs after being hit or falling?		
21. Have you ever become ill during exercising in the heat?		
22. Do you or someone in your family have sickle cell trait or disease?		
23. Have you ever had, or do you have problems with your eyes or vision?		
24. Do you worry much about your weight?		
25. Are you trying or has anyone recommended you gain or lose weight?		
26. Are you on a special diet or do you avoid certain types of foods or food groups?		
27. Have you ever had an eating disorder?		
FEMALES ONLY		
28. Have you ever had a menstrual period?		
29. How old were you when you had your first menstrual period? _____		
30. When was your most recent menstrual period? _____________		
31. How many periods have you *had* in the last 12 months? _____		

Please explain here any of the above questions that were answered YES: ______

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

Athlete Signature: ______ **Date**:______ **Parent/Guardian Signature**: ______ **Date**:______

PHYSICAL EXAMINATION FORM *Recommended Physical – Stays with Primary Care Practitioner (PCP).

HEALTH CARE PROVIDER REMINDERS:

1. Consider additional questions on more sensitive issues

*Do you feel stressed out or under a lot of pressure?
*Do you feel safe at your home or residence?
*Do you ever feel sad, hopeless, depressed, or anxious?
*Do you wear a seatbelt, use a helmet, and use condoms?
*Do you drink alcohol or use any other drugs?
*Have you ever tried cigarettes, chewing tobacco, snuff, dip, vaping, or nicotine pouches?
*In the past 30 days, did you use cigarettes, chewing tobacco, snuff, dip, vape, or nicotine pouches?
*Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
*Have you ever taken any supplements to help you gain or lose weight, or improve your performance?

2. This form must be used in conjunction with the Medical History Form and the Medical Card. Please consider reviewing questions 4-13 on the History Form related to cardiovascular symptoms. Consider ECG, echocardiogram, echocardiography, referral to Cardiologist for abnormal cardiac history and/or examination findings.

Name ________________________________ **Date of Birth** ____________________

Height ____________ Weight ____________ BP ______/______ Pulse ____________

	EXAMINATION	NORMAL	ABNORMAL FINDINGS
MEDICAL	Appearance * Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse MVP, aortic insufficiency)		
	Eyes/Ears/Nose/Throat *Pupils equal *Hearing		
	Lymph nodes		
	Heart *Murmurs (auscultation standing, supine, +/- Valsalva)		
	Lungs		
	Abdomen		
	Skin *Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
	Neurological		
MUSCULOSKELETAL	Neck		
	Back		
	Shoulder and arm		
	Elbow and forearm		
	Wrist, hand, and fingers		
	Hip and thigh		
	Knee		
	Leg and ankle		
	Foot and toes		
	Functional		
	Double-leg squat test, single-leg squat test, and box drop or step drop test		

Name of Health Care Provider: ________________________________ Date of Exam: ____________________

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SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: Please complete Sections 1 & 2. Please print.) THIS FORM MUST BE SUBMITTED TO YOUR SCHOOL or uploaded in RANK ONE.

Parent Section 1: Contact /Personal Information

Student's Name:______________________________ Sport(s): ______________________________

Age: ________ Birthdate:________________ School:______________________________ Grade:____________

Parent/Guardian Name(s): ______________________________

Address: ______________________________

Phone: (H) ____________________ (C) ____________________ (W) ____________________

Other authorized person(s) to contact in case of emergency:

Name:______________________________ Phone(s):______________________________

Name:______________________________ Phone(s):______________________________

Preference of Physician (and permission to contact if needed):

Physician's Name: ____________________ Phone:______________ Hospital Preference:____________________

Insurance:______________ Policy #: ______________ Group: ______________ Phone:______________

Parent Section 2: Medical Information

Medical Illnesses:______________________________ Braces/Splints: ______________________________

Medications: ______________________________

(Any medication(s) that may need to be taken during competition require a physician's note.)

Allergies: ______________________________

Last Tetanus (Mo/Yr): ____________ Heat Disorder or Sickle Cell Trait:______________________________

Previous Head/Neck/Back Injury:______________________________

Previous Significant Injuries: ______________________________

Any Other Important Medical Information: ______________________________

**** ***Please provide up-to-date Asthma, Allergy, Diabetes, and/or Seizure Action Plan(s) as applicable.***

Parent/Guardian Signature: ______________________________ **Date:**______________

Athlete's Signature: ______________________________ **Date:**______________

Physician Section 3: Annual Clearance for Participation

________ **CLEARED WITHOUT RESTRICTIONS** **DATE OF EXAM:** ______________ **DATE OF CLEARANCE:** ______________

________ **NOT CLEARED**

________ **CLEARED WITH THE FOLLOWING RESTRICTIONS:** ______________________________

Comments: ______________________________

*****THIS FORM MUST BE SIGNED BY HEALTH CARE PROVIDER (MD/DO, NP, PA).**

Signature of Health Care Provider (MD/DO, NP, PA): ______________________________

Name of Health Care Provider (MD/DO, NP, PA) (print or type): ______________________________

Phone:____________________

Address:______________________________