Student Name:_____ DOB:_____ Grade:_____ ID:_____

Medical History Questionnaire

1. Have you ever been hospitalized overnight? Yes No
   Have you ever had surgery? Yes No
2. Are you currently taking medication? Yes No
3. Do you have any allergies (medicines, pollen, bees)? Yes No
   List allergies: _____
4. Have you ever passed out during exercise? Yes No
   Have you ever been dizzy during exercise? Yes No
   Have you ever had chest pain? Yes No
   Do you tire more quickly than your friends during exercise? Yes No
   Have you ever had high blood pressure? Yes No
   Have you ever been told you have a heart murmur? Yes No
   Have you ever had racing of your heart or skipped beats? Yes No
   Has anyone in your family died of heart problems or a sudden death before the age of 40? Yes No
   Does anyone in your family have Marfan's Syndrome? Yes No
5. Do you have any skin problems (itching, rashes, breaking out)? Yes No
6. Have you ever had a head injury? Yes No
   Have you ever been knocked out? Yes No
   Have you ever had a seizure? Yes No
   Have you ever had pain from neck into arm? Yes No
7. Have you ever had heat cramps? Yes No
   Have you ever been dizzy or passed out in the heat? Yes No
8. Do you use special pads or braces? Yes No

9. Have you ever injured (broken/fractured, sprained, or dislocated): (please check)
   ___hand/fingers ___shoulder ___hip ___shin/calf ___wrist/forearm
   ___neck ___thigh ___elbow ___chest/ribs ___knee
   ___ankle ___upper arm ___back ___stress fracture

10. Have you ever had?(Check all that apply)
    ___mononucleosis ___diabetes ___measles ___hernia
    ___sickle cell trait/disease ___headaches (*frequent*) ___ulcers ___hepatitis
    ___asthma ___eye/ear injuries ___tuberculosis ___ COVID-19

11. When was your last tetanus shot? Month _____Date _____Year_____

12. About your weight: do you think you are:
    ___just right ___too heavy/fat ___too light/thin

13. For Females:
    When was your first period and how old were you? _____
    When was your last period? _____

14. Please feel free to ask the doctor to address any questions/concerns that you have_____
    _____

Explain all "Yes" responses to Questions 1-8: _____
_____
_____

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

Student Signature:_____ Parent Signature:_____ Date_____

Student Name:_____ DOB:_____ Grade:_____ ID:_____

Physical Examination (To be completed by medical personnel)

Height _____ Weight _____ BP ____/____ Pulse _____

Vision (optional) Left eye 20/____ Right eye 20/_

1.	Skin	
2.	Head	
3.	Eyes (PERL, EOMI, Fundi)	
4.	Ears, nose, throat	
5.	Neck	
6.	Lymphatic	
7.	Respiratory	
8.	Cardiovascular	
	Heart (murmurs?)	
9.	Abdomen	

10.	Genitalia (optional)	
11.	Extremities	
12.	Neurological	
13.	Orthopedic	
	Cervical spine/back	
	Arms/elbows/wrist/hands	
	Hips	
	Knees	
	Ankles / feet	
14.	Developmental	
	Tanner staging 1-5 (opt)	

√ = WNL X = omitted + = see "Notes" below

Please check one:

_____Full, unrestricted clearance

_____Not cleared. Needs clearance by specialist: (Please note below)
___Orthopedist ___Cardiologist ___Other
Notes:_____
_____

Screenings may only be performed by licensed MD, DO, PAC, and NP.

Athletic Screening performed by:

Print_____ MD / DO / PAC / NP (circle one)

Signature: _____ Date:_____

Place Practitioner Office Stamp Here (Required)