

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: _____

If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete. In the event that the student-athlete should be afflicted with a condition after initial clearance, the individual may require additional clearance paperwork be turned into the athletic trainer.

****Screenings may only be performed by licensed MD, DO, PAC, and NP.****
*****Physicals must be completed after 6/1/23*****

Athletic Screening performed by:

Print _____ MD / DO / PAC / NP (circle one)

Signature: _____ Date: _____

Place Practitioner Office Stamp Here (Required)