

SCHOOL SPORTS PHYSICAL EXAMINATION

Name: _____ Student ID # _____ Birth Date: _____
Grade _____ Sport: _____ Exam Date: _____ Male ■ Female ■
Address: _____ City: _____ Zip: _____
Phone: _____ School _____

HISTORY

- | | Yes | No | |
|-------|-----|----|--|
| 1 a. | ■ | ■ | Have you had any illness/injury recently, or do you have an illness/injury now? |
| b. | ■ | ■ | Have you had a medical problem, illness or injury since your last exam? |
| c. | ■ | ■ | Do you have any chronic or recurrent illness? |
| d. | ■ | ■ | Have you ever had any illness lasting more than a week? |
| e. | ■ | ■ | Have you ever been hospitalized overnight? |
| f. | ■ | ■ | Have you had any surgery other than tonsillectomy? |
| g. | ■ | ■ | Have you ever had any injuries requiring treatment by a physician? |
| h. | ■ | ■ | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| 2. | ■ | ■ | Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)? |
| 3. | ■ | ■ | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4 a. | ■ | ■ | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| b. | ■ | ■ | Do you tire more easily or quickly than your friends during exercise? |
| c. | ■ | ■ | Have you ever had any problem with your blood pressure or your heart? |
| d. | ■ | ■ | Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5. | ■ | ■ | Do you have any skin problems (acne, itching, rashes, etc.)? |
| 6 a. | ■ | ■ | Have you ever had fainting, convulsions, seizures or severe dizziness? |
| b. | ■ | ■ | Do you have frequent severe headaches? |
| c. | ■ | ■ | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| d. | ■ | ■ | Have you ever been "knocked out" or "passed out"? |
| e. | ■ | ■ | Have you ever had a neck or head injury? |
| 7. | ■ | ■ | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. | ■ | ■ | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9 a. | ■ | ■ | Do you wear eyeglasses, contact lenses or protective eye wear? |
| b. | ■ | ■ | Have you had any problem with your eyes or vision? |
| 10. | ■ | ■ | Do you wear any dental appliance such as braces, bridge, plate, retainer? |
| 11 a. | ■ | ■ | Have you ever had a knee injury? |
| b. | ■ | ■ | Have you ever had an ankle injury? |
| c. | ■ | ■ | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| d. | ■ | ■ | Have you ever had a broken bone (fracture)? |
| e. | ■ | ■ | Have you ever had a cast, splint, or had to use crutches? |
| f. | ■ | ■ | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. | ■ | ■ | Has it been more than 5 years since your last tetanus booster shot? |
| 13. | ■ | ■ | Are you worried about your weight? |
| 14. | ■ | ■ | FEMALES: Have you any menstrual problems? |
| 15. | ■ | ■ | Have you any medical concerns about participating in your sport? |

ATHLETE SHOULD NOT WRITE BELOW THIS LINE

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number:) _____

- Examiner's Note: ■ This examination is for participation at the junior high level (grades 7 & 8)
■ This examination is for participation at the senior high school level (grades 9 - 12)

