



**STUDENT HISTORY AND PHYSICAL**

<b>OFFICE USE ONLY:</b> HEIGHT_____ WEIGHT_____ Urinalysis_____ Blood Pressure_____
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PARENTS/GUARDIAN/ATHLETE - PLEASE ANSWER ALL QUESTIONS

GENERAL

CIRCLE ONE BELOW:

- |   |     |    |
|---|-----|----|
| 1. Do you have any allergies (medicine, bees, or other stinging insects)? | Yes | No |
| 2. Have you ever been hospitalized?                                       | Yes | No |
| 3. Have you ever had surgery?   | Yes | No |
| 4. Are you presently taking any medication or pills?                      | Yes | No |
| 5. Do you have any skin problems (itching, rashes, acne)?                 | Yes | No |
| 6. Have you had any other medical problems (asthma, diabetes, etc.)       | Yes | No |
| 7. Have you had a medical problem or injury since your last evaluation?   | Yes | No |

Explain "Yes" answers: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

HEART/LUNG

- |  |     |    |
|--|-----|----|
| 1. Have you ever passed out during or after exercise?                                | Yes | No |
| 2. Have you ever been dizzy during or after exercise?                                | Yes | No |
| 3. Have you ever had chest pain during or after exercise?                            | Yes | No |
| 4. Do you tire more quickly than your friends during exercise?                       | Yes | No |
| 5. Have you ever had high blood pressure?  | Yes | No |
| 6. Have you ever had or been told you have a heart murmur or rheumatic fever?        | Yes | No |
| 7. Have you ever had racing of your heart or skipped heartbeats?                     | Yes | No |
| 8. Has anyone in your family died of heart problems or a sudden death before age 50? | Yes | No |
| 9. Have you ever had heat or muscle cramps?  | Yes | No |
| 10. Have you ever been dizzy or passed out in the heat?                              | Yes | No |
| 11. Do you have trouble breathing or do you cough during or after activity?          | Yes | No |

Explain "Yes" answers: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

EAR, EYES, NOSE, AND THROAT

- |   |     |    |
|---|-----|----|
| 1. Have you ever had any problems with your eyes or vision? | Yes | No |
| 2. Do you wear glasses, contacts, or protective eye wear?   | Yes | No |
| 3. Do you have a known hearing loss?                        | Yes | No |

Explain "Yes" answers: \_\_\_\_\_  
 \_\_\_\_\_

MUSCULO-SKELETAL/NEUROLOGICAL

- |   |     |    |
|---|-----|----|
| 1. Have you ever had a head injury?   | Yes | No |
| 2. Have you ever been knocked out or unconscious?   | Yes | No |
| 3. Have you ever had a seizure?   | Yes | No |
| 4. Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones or joints? | Yes | No |

- |                                |                                   |                                    |                               |                                |                                |
|--------------------------------|-----------------------------------|------------------------------------|-------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> Head  | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thigh     | <input type="checkbox"/> Neck | <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee  |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Forearm  | <input type="checkbox"/> Shin/calf | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Hip   | <input type="checkbox"/> Hand     | <input type="checkbox"/> Foot      |                               |                                |                                |

Explain "Yes" answers: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

HERNIA/REPRODUCTIVE

QUESTIONS FOR FEMALES ONLY

1. At what age was your first menstrual period? \_\_\_\_\_
2. When was your last menstrual period? \_\_\_\_\_
3. What was the longest time between your periods last year? \_\_\_\_\_

Explain: \_\_\_\_\_  
 \_\_\_\_\_

ABDOMEN

- |   |     |    |
|---|-----|----|
| 1. Have you ever had abdominal surgery or problems? | Yes | No |
| 2. Have you had hepatitis or mononucleosis?         | Yes | No |

Explain: \_\_\_\_\_

I certify that I have, on this date, examined the above-named student and recommend him/her as being physically able to participate in supervised activities except as indicated below.

Limitations and restrictions: \_\_\_\_\_

Date:\_\_\_\_\_ Examining Physician: \_\_\_\_\_