

STUDENT HISTORY AND PHYSICAL

OFFICE USE ONLY: 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: _____