

MEDICAL HISTORY FOR PHYSICAL EXAM AND/OR ATHLETIC PARTICIPATION

Name _____ Date of Birth _____ Grade _____

Address _____ Health Care Provider _____

Sport(s): Fall _____ Winter _____ Spring _____

Check any of the following conditions, disorders or diseases that apply to the student.

_____ Asthma _____ Diabetes _____ Cystic Fibrosis _____ Thyroid Disease
_____ Blood Disease _____ Tourette's Syndrome _____ Mononucleosis _____ ADHD
_____ Kidney or bladder problem _____ Seizure disorder

Please indicate those conditions that the student has or has had in the past. Give month/year if known.

Head injury _____

Concussion _____

Knocked out, unconscious, or loss of memory _____

Numbness or tingling _____

Stinger/burner or pinched nerve _____

Frequent headaches _____

Eye or vision problems _____

Vision in one eye only _____

Glasses or contact lenses _____

Ear problems or hearing loss _____

Frequent ear infections _____

Hole in ear drum _____

Sinus infection _____

Frequent cold or sore throat _____

Dental bridge, brace, cap, or plate _____

Heart problem/murmur _____

Irregular heart/pulse rate _____

Chest pain, dizziness or passing out *during or after*

Exercise _____

Racing heart, palpitations or skipped heart beats *during*

Exercise _____

exercise _____

Blood relative died of heart problem or sudden death

Before age 50 _____

High blood pressure or high cholesterol _____

Severe viral infection within the last month _____

Trouble breathing or coughing during or after exercise _____

Dizziness or passed out in the heat _____

Spleen injury or condition _____

Stomach problems _____

Recurrent diarrhea _____

Age of first menstrual period _____

Absent or irregular periods _____

Disabling cramps with period _____

Absent or undescended testicle _____

Hernia _____

Weight gain or loss in last year _____

Emotional problems _____

Stress, anxiety, depression _____

Skin condition _____

Allergies: Seasonal _____ Food _____

medicine _____ Beesting _____

Rash or hives after exercise _____

Hospitalization (date/reason) _____

Operation (date/reason) _____

Medication, pills, inhaler (prescription or OTC) _____

Supplements or herbals _____

Injury or problem: strain, sprain, dislocation, broken

bone, swelling

Neck _____

Back _____

Chest _____

Shoulder _____

Upper arm _____

Elbow _____

Forearm _____

Wrist _____

Hand _____

Finger _____

Hip _____

Thigh _____

Knee _____

Shin/calf _____

Ankle _____

Foot _____

Special equipment: Knee or ankle brace, orthotics,

protective cup _____

Neuromuscular problem(s) _____

Poor coordination/weakness _____

Any special educational needs? _____

Are there any significant family problems that we should be aware of? _____

Have there been any changes or additions in the family in the past year? (example: health problems, changes in marital status, change in occupation, new brother or sister) _____

Signature of Student _____ Date _____

Signature of Parent/Guardian _____ Date _____

I prefer: Private physical _____

School physical _____