

Sports Medical Questionnaire

Athlete's Name: _____ Sex _____ Age _____
 DOB _____ Grade _____ Sport _____
 Home Address: _____
 Home Phone: _____ Parent's Work Phone: _____
 Personal Physician: _____ Date of Last Exam _____ Phone: _____
 Personal Dentist: _____ Phone: _____
 Health Insurance Company: _____

	Fresh.		Soph.		Junior		Senior	
	Y	N	Y	N	Y	N	Y	N
1. Have you been hospitalized or had surgery in the last two years?	Y	N	Y	N	Y	N	Y	N
2. Are you presently taking any medications?	Y	N	Y	N	Y	N	Y	N
3. Do you have any allergies (medications, bees, etc)?	Y	N	Y	N	Y	N	Y	N
4. Have you ever been told you have a heart murmur?	Y	N	Y	N	Y	N	Y	N
5. Have you ever had any seizures or fainting spells?	Y	N	Y	N	Y	N	Y	N
6. Do you have any skin problems (itching, rashes, acne)?	Y	N	Y	N	Y	N	Y	N
7. Have you ever had a head injury or been knocked unconscious?	Y	N	Y	N	Y	N	Y	N
8. Have you ever had a stinger, burner, or pinched nerve?	Y	N	Y	N	Y	N	Y	N
9. Have you ever been told by a physician that you have asthma?	Y	N	Y	N	Y	N	Y	N
10. Do you wear glasses/contacts or have any other problems with your eyes?	Y	N	Y	N	Y	N	Y	N
11. Have you ever had any fractures, dislocations or any repeated strains/sprains?	Y	N	Y	N	Y	N	Y	N
12. Have you had any other medical problems (mononucleosis, diabetes, anemia, thyroid trouble, etc)	Y	N	Y	N	Y	N	Y	N
13. Have you ever had a hernia?	Y	N	Y	N	Y	N	Y	N

Females Only:

When was your first menstrual period? _____

When was your last menstrual period? _____

What was the longest time between menstrual periods, last year? _____

Are you currently having any difficulty with your periods? Yes No

If you answered "Yes" to any of the questions above, please explain in detail below: _____

This screening is meant as a pre-athletic participation screening only and is not to be meant to take place of a recommended annual physical by your primary physician.

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Parent's signature: _____ Date: _____

Athlete's signature: _____ Date: _____

Screening Results

Athlete's Name: _____ DOB ___/___/___ Today's Date _____

Height: _____ Weight: _____ BP _____/_____/____ Pulse _____

Vision: Right 20 / _____ Corrected: Yes No Pupils: _____

Check the appropriate column if normal

System	Fr	So	Ju	Se	Abnormal Findings (please note year)
Cardiopulmonary					
Pulses					
Heart					
Lungs					
Skin					
Abdomen					
Musculoskeletal					
Neck					
Shoulder					
Elbow					
Wrist/hand					
Back					
Knee					
Ankle/Foot					
Other:					

<p style="text-align: center;">Freshman</p> <p>a. Cleared for full participation</p> <p>b. Not cleared due to: _____</p> <p>_____</p> <p>c. Physician's Name: _____</p> <p>Physician's Signature: _____</p> <p>Physician's Phone #: _____</p>	<p style="text-align: center;">Sophomore</p> <p>a. Cleared for full participation</p> <p>b. Not cleared due to: _____</p> <p>_____</p> <p>c. Physician's Name: _____</p> <p>Physician's Signature: _____</p> <p>Physician's Phone #: _____</p>
<p style="text-align: center;">Junior</p> <p>a. Cleared for full participation</p> <p>b. Not cleared due to: _____</p> <p>_____</p> <p>c. Physician's Name: _____</p> <p>Physician's Signature: _____</p> <p>Physician's Phone #: _____</p>	<p style="text-align: center;">Senior</p> <p>a. Cleared for full participation</p> <p>b. Not cleared due to: _____</p> <p>_____</p> <p>c. Physician's Name: _____</p> <p>Physician's Signature: _____</p> <p>Physician's Phone #: _____</p>

Additional Comments: _____
