THIS QUESTIONAIRE IS FOR PATIENT'S MEDICAL RECORD ONLY DO NOT RETURN TO SCHOOL PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT

1. Hasa a doctor ever denied or restricted your participation in sports? 2. Do you have a medical condition (ashmal/diabetes)? 2. Do you have a medical condition (ashmal/diabetes)? 3. Has any relative died of a heart condition suddenly before age 50? 4. Has any relative died of a heart condition suddenly before age 50? 5. Do you or your relatives have a history of: a. Heart muscle disease such as hypertrophic cardiomyopath? b. Arrhyfmia, irregular hythm, pacemaker WPW (Wolf Parkinson White). Long QT syndrome or other cardiac problem? c. Marfan Syndrome? 3. Does your heart race or skip beats during exercise? 4. Have you ever passed out or nearly passed out during or after exercise? 5. Have you ever passed out or nearly passed out during or after exercise? 6. Do you have a history of high blood pressure? 7. History of unexplained dizziness with exercise? 8. History of unexplained dizziness with exercise? 9. Have you ever had an ECG or Echocardiogram test for your heart? 10. History of congenital heart disease? 11. History of congenital heart disease? 12. History of congenital heart disease? 13. History of Carditis or Kawasaki disease? 14. Have you ever had an ECG or Echocardiogram test for your heart? 15. History of fine passed out prostable diverses or possible of possible properties of your heart? 16. Do you have a history of flexible properties of your heart? 17. History of congenital heart disease? 18. History of congenital heart disease? 19. Have you ever had an ECG or Echocardiogram test for your heart? 20. Have you ever been told by a doctor that you have ashmal medication? 21. Have you ever been told by a doctor that you have ashmal proposed to treate the proposed discorder in the heart of your weak and the proposed discorder in the heart of your weak and the proposed discorder in the heart of your weak and your arms or legs after being hit or or falling? 22. Have you ever been told by a doctor that you have ashmal your arms or legs after being hit or or falling? 23. Have you ever had annesia or memory lo	SPORTS PHYSICAL PHYSICIAN OFFICE FORM								
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weakness in your arms or legs after being hit or or falling? 4. History of seizures? 5. History of headaches with exercise? 6. Do you have a history of any problems with your eyes or vision? 7. Do you wear glasses or contact lenses? 8. History of neck instability (i.e. Atlantoaxial Instability) FEMALES OLDER THAN 16 (OPTIONAL): 1. Have you had no periods? 2. Have you gone more than 90 days without a period in the last 6 months? EXPLAIN "YES" ANSWERS HERE:		after a head injury?			11.	History of Hypoglycemia (low blood sugar)?	📙		
 4. History of seizures? 5. History of headaches with exercise? 6. Do you have a history of any problems with your eyes or vision? 7. Do you wear glasses or contact lenses? 8. History of neck instability (i.e. Atlantoaxial Instability) 2. Have you gone more than 90 days without a period in the last 6 months? EXPLAIN "YES" ANSWERS HERE: EXPLAIN "YES" ANSWERS HERE:	3.	weakness in your arms or legs after being hit or			FEM	ALES OLDER THAN 16 (OPTIONAL):	l!? [_]		
6. Do you have a history of any problems with your eyes or vision? 7. Do you wear glasses or contact lenses? 8. History of neck instability (i.e. Atlantoaxial Instability)		History of seizures?	H			Have you gone more than 90 days without a			
8. History of neck instability (i.e. Atlantoaxial Instability)		Do you have a history of any problems with your eyes or vision?			EXP	·			
		History of neck instability (i.e. Atlantoaxial							
I have but a tata that to the back of much manufaday were an account to the a back account the control of the c	1 L					and any complete and assumed			
I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Signature of athlete: Date:									

SPORTS PHYSICAL SCHOOL FORM

I grant permission to release the information below to School Personnel. Signature of Parent/Guardian: NAME: ______ Date of Birth: _____ Student ID: _____ _____ School: _____ Grade: Sports: Emergency Contact: _____ Cell Phone: _____ Home Phone: _____ MEDICATIONS: ALLERGIES: Height: _____ Weight: ____ BMI: ____ Pulse: ____ BP: ___/___ Date of Exam: ____ Vision: R 20/__ L 20/__ Both 20/__ Corrected: TY N HEARING: Passed Right/Left <25dcbls (all frequencies) Failed_____ Not Done U/A: Normal ____ REQUIRED IMMUNIZATIONS: Measles, Mumps, Rubella, Hepatitis B, Polio, Tetanus, Pertussis, and Varicella/illness. Up to date (See Attached Vaccine Documentation) Not up to date, Vaccines Needed: Baseline Concussion Assessment Complete (recommended, if not done, school will conduct the screening) NORMAL ABNORMAL FINDINGS MEDICAL: **General Appearance** Head eyes/ears/nose/throat Neck Respiratory Heart Pulses Abdomen Skin Neuro **Lymph Nodes** Genitourinary (males only) ABNORMAL FINDINGS NORMAL MUSCULOSKELETAL: Back (including scoliosis screen) Shoulder/Arm Elbow/Forearm Wrist/Hand/Fingers Hip/Thigh Knee Leg/Ankle Foot/Toes Assessment/Plan: OFFICE STAMP: Cleared for all sports without restrictions Not Cleared for: All sports Certain sports: Reason: Deferred requires further evaluation (See Recommendations Below): Cleared with restrictions (See Recommendations Below): Recommendations: ___ Name of Physician (print): ______ Address: _____ Phone:

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.

Rev. March 2012

Signature of Physician:

, M.D., D.O., or N.P. Date: