Lake Health
Preparticipation Sports Physical Screening and Exam

Name _____

Birth Date _____

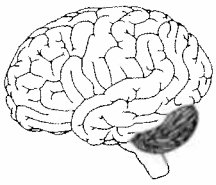
Social Security # _____

Sport _____

	Yes	No
1. Have you ever had a rash or hives develop during or after exercise?		
Have you ever passed out during or after exercise?		
Have you ever been dizzy during or after exercise?		
Do you get tired more quickly than your friends do during exercise?		
Have you ever had racing of your heart or skipped heartbeats?		
Have you had high blood pressure or high cholesterol?		
Have you ever been told you have a heart murmur?		
Has any family member or relative ever died of heart problems or of sudden death before age 50?		
Is there a family history of heart problems in a close relative younger than age 50? (i.e. Enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)?		
Have you ever had a severe heart infection (i.e. myocarditis or pericarditis)?		
Is there a family history of Marfan's Syndrome?		
Has a physician ever denied or restricted your participation in sports for any heart problems?		
Have you ever had discomfort, pain, or pressure in your chest during exercise?		
Has a doctor ever ordered a test for your heart? (i.e. ECG, echocardiogram)		

Explain any yes answers: _____

2. Have you ever had a head injury or concussion?		
Have you ever been knocked out, become unconscious, or lost your memory?		
Do you have severe or frequent headaches or develop headaches with exercise?		
Have you ever had an x-ray for or been told you have an atlantoaxial (neck) instability?		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
Have you ever been unable to move your arms or legs after being hit or falling?		
Have you ever had a seizure?		
Are you epileptic?		



Explain any yes answers: _____

3. Have you ever become ill or have severe cramps from exercising in the heat?		

Explain any yes answers: _____

4. Do you cough, wheeze, or have trouble breathing during or after exercise?		
Do you have asthma?		
Are you using an inhaler?		
Do you have seasonal allergies that require medical treatment?		

Explain any yes answers: _____

	Yes	No
5. Have you had a medical illness or injury since your last sports physical?	☐	☐
Do you have an ongoing or chronic illness? (i.e. Diabetes)	☐	☐
Have you had a severe viral infection within the last month (i.e. mononucleosis)?	☐	☐
Explain any yes answers: _____		
6. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
Explain any yes answers: _____		
7. Are you currently taking any prescription or non-prescription (over the counter) medications or pill?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or to improve performance?	☐	☐
Explain any yes answers: _____		
8. Do you think you are in good health?	☐	☐
Has your doctor ever told you or someone in your family has the sickle cell trait or sickle cell disease?	☐	☐
Have you ever had surgery?	☐	☐
Explain any yes answers: _____		
9. Do you have any allergies (i.e. pollen, medicine, food, or insect sting?)?	☐	☐
Explain: _____		
10. Do you have any current skin problems (rashes, acne, warts, fungus, blisters, itching)?	☐	☐
Explain: _____		
11. Do you use any special protective or correctional equipment or devices that aren't usually used for your sport or position (i.e. braces, neck roll, orthotics, oral retainer, or hearing aid)?	☐	☐
Explain: _____		
12. Have you had problems with your eyes or vision?	☐	☐
Do you wear glasses or contact lenses?	☐	☐
Do you wear protective eyewear such as goggles or a face shield?	☐	☐
Explain any yes answers: _____		
13. Have you ever had a sprain, strain or swelling after injury?	☐	☐
Have you ever fractured or broken and bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
If yes, please check the appropriate box: ☐ Head ☐ Neck ☐ Back ☐ Chest ☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Finger ☐ Hip ☐ Thigh ☐ Knee ☐ Shin ☐ Calf ☐ Ankle ☐ Foot		
Explain any yes answers: _____		
14. Are you trying to gain or lose weight?	☐	☐
Do you lose weight regularly to meet requirements for your sport?	☐	☐
Are you happy with your current weight?	☐	☐
Do you limit or carefully control what you eat?	☐	☐
Has anyone recommended you change your weight or eating habits?	☐	☐
Explain: _____		
15. Do you feel stressed out?	☐	☐
Explain: _____		
16. Were you born without or are you missing a kidney, eye, testicle, or any other organ?	☐	☐
Explain: _____		
17. Has a doctor ever denied or restricted you participation in sports for any reason?	☐	☐
Explain: _____		
18. Do you have any other concerns that you would like to discuss with a doctor?	☐	☐
Explain: _____		

FEMALES ONLY:

19. When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of the next? _____

How many periods did you have last year? _____

What was the longest time between periods in the last year? _____

Date of Exam _____

Date of Exam _____

Physical Examination

Student's Name _____ Birth Date _____
Last First Middle

Height _____ Weight _____ Pulse _____ Blood Pressure _____ / _____

Vision R 20/ _____ L 20/ _____ Corrected? Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
MEDICAL			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Upper Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Lower Leg/Ankle			
Foot			

*Station-based exam only

Clearance

☐ **Cleared**

☐ **Cleared after completing evaluation/rehabilitation for:** _____

☐ **Not Cleared for:** _____ **Reason:** _____

Recommendations: _____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities **(Note exceptions above)**.

Physician's Name and Address (stamp or print)
If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Examiner's Signature / Date

Examiner's Telephone Number

NOTE: HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION