

Please print

Sport(s) _____

Student-Athlete's Name: _____ Birth Date: _____ Sex: Male ___ Female ___

Social Security Number: _____ - _____ - _____

Past Medical History

DO NOT LEAVE ANY BLANKS!

1. Have you ever had any of the following problems after exercising?

- | | |
|---|--------------------|
| Passing out | YES _____ NO _____ |
| Light headedness/dizziness | YES _____ NO _____ |
| Coughing | YES _____ NO _____ |
| Asthma attacks | YES _____ NO _____ |
| Extreme shortness of breath | YES _____ NO _____ |
| Unusual racing heart or skipping heartbeats | YES _____ NO _____ |
| Do you get tired more quickly than your friends | YES _____ NO _____ |

2. Have you ever been told you have a heart condition or heart murmur?

YES _____ NO _____

Has anyone in your family died suddenly before age 50 (including grandparents, aunts, uncles, cousins)?

YES _____ NO _____

3. INJURIES: Have you ever had:

- | | |
|------------------------|--------------------|
| Concussion/knocked out | YES _____ NO _____ |
| Neck pain/injury | YES _____ NO _____ |
| Ligament/muscle injury | YES _____ NO _____ |
| Sprains/Strains | YES _____ NO _____ |
| Joint injury | YES _____ NO _____ |
| Broken bone | YES _____ NO _____ |
| Back pain/injury | YES _____ NO _____ |
| Dislocations | YES _____ NO _____ |

4. MEDICAL: Have you had:

- | | |
|-----------------------------|--------------------|
| Heat stroke/heat exhaustion | YES _____ NO _____ |
| Diabetes | YES _____ NO _____ |
| Mononucleosis | YES _____ NO _____ |
| Bleeding problems | YES _____ NO _____ |
| Hernia | YES _____ NO _____ |
| Seizures | YES _____ NO _____ |
| Menstrual problems | YES _____ NO _____ |
| Allergies | _____ |

5. DO YOU HAVE ANY CONDITIONS REQUIRING CONSISTENT MEDICATIONS?

6. List ALL medicines, supplements, energy drinks and vitamins you are currently taking (include asthma inhalers and contraceptive medication)

7. MALES ONLY

- | | |
|--|--------------------|
| Have you ever had a hernia? | YES _____ NO _____ |
| Do you have two functioning testicles? | YES _____ NO _____ |

8. FEMALES ONLY

- When was your first menstrual period? _____
When was your most recent period? _____
How many days do you typically have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods? _____

9. Do you have any medical conditions not listed above? YES _____ NO _____ If so what? _____

10. Do you worry about your weight? YES _____ NO _____

11. Do you avoid eating meat? YES _____ NO _____

12. Do you avoid eating dairy foods? YES _____ NO _____

The above information is correct: _____ Date _____

(Student-athlete's signature)

Parent's Signature: _____ Date _____

(required if under 18 years of age)

PHYSICL EXAMINATION
TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Pulse _____ B/P _____

Visual acuity L _____ R _____
Wearing Contacts / Glasses Yes ____ No ____

Medical Examination OK PROBLEM COMMENT

Medical Examination	OK	PROBLEM	COMMENT
Dental			
Eyes/Fundus			
Ears, Nose, Throat			
Head & Neck			
Skin & Scalp			
Lymphatics			
Thorax			
Lungs			
Heart			
Abdomen			
Hernia			
Genitalia			
Neurologic			

Orthopedic Examination OK PROBLEM COMMENT

Orthopedic Examination	OK	PROBLEM	COMMENT
Neck & Shoulder			
Elbow, Hand & Wrist			
Back			
Knee			
Ankle			
Feet			
Flexibility			
Other			

REFERRAL OR F/U PLAN: MD ATC LAB X-RAY
 MEDICAL RECORDS _____
 OTHER _____

CLEARANCE

- Full Unlimited Participation
- No Athletic Participation
- Limited Participation, Restrictions: _____
- Clearance Withheld Until: _____

**If clearance is restricted
please fax copy of form to
C.O.D. Athletic Training
(630) 858-5404**

Physician's Name Printed: _____ MD DO

**Examination must be
performed by or signed off
by MD / DO**

Physician's Address: _____ Phone: _____

Physician's Signature: _____ Date _____