Heritage Academy Sports Physical

Student: _____

This portion is to be filled out by the patient and their parents prior to seeing the physician.

Y	N	Yes = Y No = N
		Have you had a medical illness or injury since your last check-up or sports physical?
		Do you have an ongoing or chronic illness?
(Explain Yes Answers)		
		Have you ever been hospitalized overnight?
		Have you ever had surgery?
(Explain Yes Answers)		
		Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?
		Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
(List medications, herbal and nutritional supplements, vitamins)		
		Do you have any allergies (For example, to pollen, medicine, food, or stinging insects)?
		Have you ever had a rash or hives develop during or after exercise?
(Explain Yes Answers)		
		Have you ever passed out during or after exercise?
		Have you ever been dizzy during or after exercise?
		Have you ever had chest pain 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 died of heart problems or of sudden death before age 50?
		Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
		Has a physician ever denied or restricted your participation in sports for any heart problems?
(Explain Yes Answers)		
		Do you have any current skin problem (for example, itching, rashes, acne, warts, fungus, or blisters)?
		Do you want to weigh more or less than you do now?
		Do you lose weight regularly to meet weight requirements of your sport?
		Do you feel stressed out?
(Explain Yes Answers)		

Record the dates of your most recent immunizations (shots):

Tetanus _____ Measles _____

Hepatitis B _____ Chickenpox _____

Y	N	Yes = Y No = N
		Have you ever had a head injury or concussion?
		Have you ever been knocked out, become unconscious, or lost your memory?
		Have you ever had a seizure?
		Do you have frequent or severe headaches?
		Have you ever had numbness or tingling in your arms, hands, legs, or feet?
		Have you ever had a stinger, burner, or pinched nerve?
(Explain Yes Answers)		
		Have you ever become ill from exercising in the heat?
		Do you cough, wheeze, or have trouble breathing during or after activity?
		Do you suffer from asthma?
		Do you have seasonal allergies that require medical treatment?
(Explain Yes Answers)		
		Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck rolls, foot orthotics, retainer on your teeth, hearing aids)?
(Explain Yes Answers)		
		Have you had any problems with your eyes or vision?
		Do you wear glasses, contacts, or protective eyewear?
(Explain Yes Answers)		
		Have you ever had a sprain, strain, or swelling after injury?
		Have you broken or fractured any bones or dislocated any joints?
		Have you had any problems with pain or swelling in muscles. tendons, bones, or joints?

If yes, Circle the appropriate boxes and explain below:

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin/Calf
Shoulder	Finger	Ankle
Upper Arm		Foot

FEMALES ONLY

When was your last menstrual period? _____

How old were you when you had your first menstrual period? _____

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

How many periods have you had in the 12 months? _____

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

Signature of athlete: _____ Signature of parent/guardian: _____ Date: ____-____-____

Emergency Contact: Name: _____ Relationship: _____ Phone (H)_____(W)_____

Physician Section

Sports athlete will participate in:

☐ Basketball ☐ Soccer ☐ Track ☐ Volleyball
☐ Other: _____

Height _____ Weight _____ Body fat (optional) ___ % Pulse ____ BP _____/_____ (_____/_____,_____/_____)

Vision: R 20/_____ L 20/_____ Corrected Y / N Pupils: Equal_____ Unequal_____

MEDICAL	Normal	Abnormal
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		

MUSCULOSKETAL	Normal	Abnormal
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wristband		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Describe Abnormal Findings:

CLEARANCE

[ ] Cleared

[ ] Cleared after completing evaluation/rehabilitation for: _____
_____
_____

[ ] Not cleared for: _____ Reason: _____

Recommendations: _____
_____
_____

Name of physician (print/type) _____ Date: _____

Signature of physician _____, (MD/DO/ARNP/Chiropractor)

Address_____Phone:_____