McCLURE JUNIOR HIGH SCHOOL
MEDICAL HISTORY AND PHYSICAL EXAM FORM FOR SPORTS

NAME: _____ BIRTH DATE: _____ SEX: ____ GRADE: _____

ADDRESS: _____

MEDICAL HISTORY must be completed prior to PHYSICAL EXAM.

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does you heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
15. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
16. Have you ever had any broken or fractured bones or dislocated joints?		
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
18. Have you ever had a stress fracture?		
19. Do you regularly use a brace, orthotics, or other assistive device?		
20. Do you have a bone, muscle, or joint injury that bothers you.		
21. Do any of your joints become painful, swollen, feel warm, or look red?		
22. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	YES	NO
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
24. Have you ever used an inhaler or taken asthma medicine?		
25. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
26. Do you have groin pain or a painful bulge or hernia in the groin area?		
27. Have you had infectious mononucleosis (mono) within the last month?		
28. Do you have any rashes, pressure sores, or other skin problems?		
29. Have you had a herpes or MRSA skin infection?		
30. Have you ever had a head injury or concussion?		
31. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
32. Do you have a history of seizure disorder?		
33. Do you have headaches with exercise?		
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
35. Have you ever been unable to move your arms or legs after being hit or falling?		
36. Have you ever become ill while exercising in the heat?		
37. Do you get frequent muscle cramps when exercising?		
38. Do you or someone in your family have sickle cell trait or disease?		
39. Have you had any problems with your eyes or vision?		
40. Have you had any eye injuries?		
41. Do you wear glasses or contact lenses?		
42. Do you wear protective eyewear, such as goggles or a face shield?		
43. Do you worry about your weight?		
44. Are you trying to or has anyone recommended that you gain or lose weight?		
45. Are you on a special diet or do you avoid certain types of foods?		
46. Have you ever had an eating disorder?		
47. Have you or any family member or relative been diagnosed with cancer?		
48. Do you have concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**YES**	**NO**
49. Have you ever had a menstrual period?		
50. How old were you when you had your first menstrual period?		
51. How many periods have you had in the last 12 months?		

Explain "yes" answers here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 _____

McCLURE JUNIOR HIGH SCHOOL
MEDICAL HISTORY AND PHYSICAL EXAM FORM FOR SPORTS

NAME: _____ BIRTH DATE: _____ SEX: ____ GRADE: _____

ADDRESS: _____

Physical Exam

Blood Pressure: _____ Height: _____ Weight: _____ Pulse: _____

GENERAL EXAM	N	A	Comments	NEURO & ORTHOPEDIC EXAM	N	A	Comments
General Appearance (Nutrition)				Neurologic			
Head				Neck			
Eyes (Pupils, Reaction, EOM				Shoulder			
Ears (EAC's, TM's)				Elbows			
Nose				Wrists			
Oropharynx				Hands			
Neck				Hips			
Lymphatics				Knees			
Chest				Ankles			
Heart				Spine/Scoliosis			
Lungs				Other:			
Abdomen							
Other:							

Sign-Off

☐ Full Participation ☐ Limited Participation

☐ No Participation – Requires: _____

Comments: _____

Date:

Physician: _____ Signature: _____

Address: _____ Phone: _____