Idaho State University Sports Medicine

New Athlete Physical Evaluation Form

Name:_____ Sport:_____ Bengal ID#:_____ Age:____ Date of Birth:_____

Address (local):_____

Phone (cell):_____ E-mail Address:_____

Emergency Contact: Name:_____ Relationship:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

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

_____

_____

Do you have any allergies? Yes:_____ No:_____ If yes, please indicate. Medications:_____

Foods: Pollens: Stinging Insects:

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

General Questions	Y	N
1. Has a doctor ever denied or restricted your participation in sports? Why?_____		
2. Do you have any ongoing medical conditions? Circle all that apply: Asthma Anemia Diabetes Infections Other:_____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
Heart Health Questions About You	**Y**	**N**
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 your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? Circle all that apply: High blood pressure High cholesterol Heart murmur Heart infection Kawasaki disease Other:_____		
9. Has a doctor ever ordered a test for your heart? Circle all that apply: ECG EKG Echocardiogram Other:_____		
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	**Y**	**N**
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 hypertrophic cardiomyopathy, Marfans syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
Bone and Joint Questions	**Y**	**N**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had a stress fracture?		
20. Have you ever had an injury that required? Circle all that apply: X-rays MRI CT scan Injections Therapy Brace Cast Crutches		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

Medical Questions	Y	N
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last 6 month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
Females Only	**Y**	**N**
52. Have you ever missed a menstrual period?		
53. How many periods have you had in the last 12 months?		
54. How old were you when you had your first menstrual period?		

Explain "yes" answers here:_____

_____

_____

_____

_____

_____

_____

_____

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

Athlete Signature:_____ Date:_____

Signature of parent/guardian (if necessary):_____ Date:_____

	Follow-Up questions on more sensitive issues:				Doctor Notes
1)	Do you feel stressed out or under a lot of pressure?		Yes	No	
2)	Do you ever feel sad, hopeless, depressed, or anxious?		Yes	No	
3)	Do you feel unsafe at your home or residence?		Yes	No	
4)	Have you ever tried and or use cigarettes, chewing tobacco, snuff, or dip?		Yes	No	
5)	Have you ever tried and or do you drink alcohol?		Yes	No	
6)	Have you ever tried and or do you use drugs?		Yes	No	
7)	Have you ever used anabolic steroids or any other performance supplement?		Yes	No	
8)	Have you ever used any supplements to help you gain or lose weight or improve your performance?		Yes	No	
9)	Do you wear a seat belt, use a helmet?		Yes	No	
10)	If sexually active do you use condoms and or practice safe sex?	N/A	Yes	No	

EXAMINATION
FOR OFFICIAL USE ONLY

Height: Weight: Male_____ Female____

BP: Pulse: Vision: R 20/ L 20/ Corrected: Yes or No

Medical	Normal	Abnormal Findings
Appearance: --Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat: --Pupils equal --Hearing		
Lymph nodes		
Heart: --Murmurs (auscultation standing, supine, +/- Valsalva) --Location of point of maximal impulse (PMI)		
Pulses: --Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin: --HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
Musculoskeletal	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toe		
Functional: --Duck-walk, single leg hop		

Laboratory (if indicated): Hematocrit: _____ Sickle Cell Screen: _____ D.T. given?: _____
Urinalysis: _____ Ferritin: _____ Other: _____

Cleared for all sports without restriction: Yes: _____ No: _____

Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____

_____

_____

Not cleared: _____

Pending further evaluation:_____

For any sports: _____

For certain sports: _____

Reason: _____

Recommendations: _____

_____

_____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians, as applicable).

Physician(print):_____ Supervising Physician(print):_____

Signature of Physician:_____ Signature of Supervising Physician:_____

Date:_____