AGHS PRE-PARTICIPATION FORM — HISTORY INTAKE

Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Address: _____ Grade: _____ Phone: _____

Sports: _____ Personal Physician: _____

In case of emergency, contact: _____

Name Relationship Cell# Work #

LAST NAME _____ FIRST NAME _____ GRADUATION YEAR: _____

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

1. Has a doctor ever denied or restricted your participation in sports for any reason?	Y	N
2. Do you have an ongoing medical condition ? (example: Diabetes or asthma)	Y	N
3. Are you currently taking any prescription or non-prescription medication or pills?	Y	N
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	Y	N
5. Have you ever passed out or nearly passed out DURING exercise?	Y	N
6. Have you ever passed out or nearly passed out AFTER exercise?	Y	N
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	Y	N
8. Does your heart race or skip beats during exercise?	Y	N
9. Has a doctor ever told you that you have (check all that apply): ___High Blood Pressure ___Heart Murmur ___High cholesterol ____Heart Infection		
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	Y	N
11. Has anyone in your family died for no apparent reason?	Y	N
12. Does anyone in your family have a heart problem?	Y	N
13. Has any family member or relative died of heart problems or of sudden death before age 50?	Y	N
14. Does anyone in your family have Marfan syndrome?	Y	N
15. Have you ever spent the night in a hospital?	Y	N
16. Have you ever had surgery?	Y	N
17. Have you ever had an injury like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle the affected area below:	Y	N
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	Y	N
19. Have you had a bone or joint injury that required xrays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, circle below:	Y	N

HEAD	NECK	SHOULDER	UPPER ARM	ELBOW	FOREARM	HAND/ FINGERS	CHEST
UPPER BACK	LOWER BACK	HIP	THIGH	KNEE	CALF/SHIN	ANKLE	FOOT/ TOES

20. Have you ever had a stress fracture?	Y	N
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Y	N
22. Do you regularly use a brace or assistive device?	Y	N
23. Has a doctor ever told you that you have asthma or allergies?	Y	N
24. Do you cough, wheeze or have difficulty breathing during or after exercise?	Y	N
25. Is there anyone in your family who has asthma?	Y	N
26. Have you ever used an inhaler or taken asthma medicine?	Y	N
27. Were you born without or are you missing a kidney, an eye, a testicle or any other organ?	Y	N
28. Have you had infectious mononucleosis (mono) within the last month?	Y	N
29. Do you have any rashes, pressure sores or other skin problems?	Y	N
30. Have you had a herpes skin infection?	Y	N
31. Have you ever had a head injury or concussion?	Y	N
32. Have you been hit in the head or been confused or lost your memory?	Y	N
33. Have you ever had a seizure?	Y	N
34. Do you have headaches with exercise?	Y	N
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Y	N
36. Have you ever been unable to move your arms or legs after being hit or failing?	Y	N
37. When exercising in the heat, do you have severe muscle cramps or become ill?	Y	N
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Y	N
39. Have you had any problems with your eyes or vision?	Y	N
40. Do you wear glasses or contact lenses?	Y	N
41. Do you wear protective eyewear such as goggles or a face shield?	Y	N
42. Are you happy with your weight?	Y	N
43. Are you trying to lose weight?	Y	N
44. Has anyone recommended you change your weight or eating habits?	Y	N
45. Do you limit or carefully control what you eat?	Y	N
46. Do you have any concerns that you would like to discuss with a doctor?	Y	N
FEMALES ONLY 47. Have you ever had a menstrual period?	Y	N
48. How old were you when you had your first period?	_____	
49. How many period have you had in the last 12 mo.?	_____	

Explain "Yes" answers here: _____

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

Signature of Athlete: _____ **Signature of Parent/Guardian:** _____ **Date:** _____

PHYSICAL EXAMINATION

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

Student's Name:_____ DOB:_____
Last First Middle

Height:_____ Weight:_____ %Body Fat (optional):_____ Pulse:_____ BP_____/_____

Vision R 20/____ L 20/_____ Corrected: Yes / No 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/Arm *			
Elbow/Forearm *			
Wrist/Hand *			
Hip/Thigh *			
Knee *			
Leg/Ankle *			
Foot *			

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) Examiner's Signature Date

If the Advanced Nurse Practitioner (A.N.P) performed the exam, please provide the name and address of collaborating physician or physician group: _____

_____

Address Examiner's Telephone Number