



Intercollegiate Athletics Athletic Medical History

Name _____ Birth Date _____ Sport _____

Parent/guardian _____ Phone _____

Parent/guardian address _____

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

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?
Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?
Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity?
Do you have asthma?
Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|----------------------------------|------------------------------------|
| 10. 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 roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had any problems with your eyes or vision?
Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. 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 other problems with pain or swelling in muscles, tendons, bones, or joints?
<i>If yes, check appropriate box and explain below.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper arm | | <input type="checkbox"/> Foot |
| 13. Do you want to weigh more or less than you do now?
Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Record the dates of your most recent immunizations (shots) for:
Tetanus _____ Measles _____
Hepatitis B _____ Chickenpox _____ | | |

EMALES ONLY

16. When was your first menstrual period? _____
When was your most recent 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 last year? _____
What was the longest time between periods in the last year? _____

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 _____

Physical Exam

General

- _____ Head/scalp
- _____ Eyes/pupils
- _____ Mouth
- _____ Teeth/gums
- _____ Ears/hearing
- _____ Nose/sinus
- _____ Throat/pharynx
- _____ Thyroid
- _____ Lymph nodes
- _____ Heart/lung sounds
- _____ Heart condition
- _____ Chest/lungs
- _____ Breasts
- _____ Liver
- _____ Spleen
- _____ Abdomen
- _____ Hernial rings
- _____ Genitalia
- _____ Inguinal nodes
- _____ Skin
- _____ Nailbeds - fingers/toes

Orthopedic

- _____ Neck
- _____ Jaw
- _____ Shoulders
- _____ Elbows
- _____ Wrists
- _____ Fingers
- _____ Spine
- _____ Ribs/sternum
- _____ Pelvis
- _____ Hips
- _____ Knees
- _____ Ankles
- _____ Feet/toes
- _____ Gait pattern

Neurological

- _____ Reflexes
- _____ Atrophy
- _____ Paralysis
- _____ Other

Height _____ Weight _____

Blood pressure _____ Pulse _____

Temp. _____ Respiration _____

Vision: R _____ L _____ Hearing: R _____ L _____

ARE OTHER TESTS/EXAMS NEEDED? yes no

What? _____

Hematology (optional) _____

Urinalysis (optional) _____

Currently recovering from an illness? _____

Any family history of the above conditions? yes no _____ Who/What _____

_____ Currently taking

any medication/supplements? _____

_____ Allergic to any medication/supplements?

_____ Hospitalized in the last twelve

months yes no If so why? _____

Was there any pre-existing conditions that prevented or limited athletic participation within the last twelve (12) months? yes no Has it been resolved? yes no

Further action? _____

Comments _____

cleared not cleared for the following:

On the basis of this examination requested by Yavapai College, I have found no reason which would make it medically inadvisable for this student athlete to compete in all aspects of intercollegiate athletics.

Examining physician _____ *signature*

Date of exam _____

Name _____ *print or type*

Address _____

Phone _____

This physical must be taken no earlier than June 1st.