

Sport(s) _____

**CENTRAL CHRISTIAN COLLEGE
PHYSICAL EXAMINATION FORM**

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the student and reviewed by examining provider

Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____

Student's Name: _____ Sex: M F (circle one) Age: _____

Date of Birth: ___/___/_____ Home Phone: (_____) _____

Sport(s): _____

Physician's Name: _____ Phone: _____

EMERGENCY CONTACT INFORMATION

Name of parent/ guardian: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:

- a. Restriction from sports for a health related problem? Y / N
- b. An injury or illness since your last exam? Y / N
- c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N
 - (1.) An inhaler or other prescription medicine to control asthma? Y / N
- d. Any prescribed or over the counter medications that you take on a regular basis? Y / N
- e. Any surgery or hospitalization? Y / N
- f. Any allergies to medications? Y / N
- g. Any anemias, blood disorders, sickle cell disease/trait, or clotting disorders? Y / N
- h. Hepatitis B or C, HIV/AIDS, or infectious mononucleosis? Y / N

Explain all "yes" answers here (include relevant dates):

List all medications currently taking here:

2. Have you ever had, or do you currently have, and of the following HEAD-RELATED conditions:

- a. Concussion or head injury How many? _____ Y / N
- b. Memory loss? Y / N
- c. Knocked out? Y / N
- d. A seizure? Y / N
- e. Frequent or severe headaches (With or without exercise)? Y / N

Explain all "yes" answers here (include relevant dates):

3. Have you ever had, or do you currently have ,any of the following HEART-RELATED conditions:

- a. Restriction from sports for heart problems? Y / N
- b. Chest pain or discomfort? Y / N
- c. Heart murmur? Y / N
- d. High blood pressure? Y / N
- e. Elevated cholesterol level? Y / N
- f. Heart infection? Y / N
- g. Dizziness or passing out during or after exercise without known cause? Y / N
- h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test)? Y / N
- i. Racing or skipped heartbeats? Y / N
- j. Unexplained difficulty breathing or fatigue during exercise? Y / N
- k. Any family member (blood relative):
 - i. Under 50 with a heart condition? Y / N
 - ii. Died of a heart problem before age 50? If yes, what age? _____ Y / N
 - iii. Died with no known reason? Y / N
 - iv. Died while exercising? If yes, was it during or after? (Circle one.) Y / N

Explain all "yes" answers here (include relevant dates):

4. Have you ever had, or do you currently have, any of the following eye, ear or throat conditions:

- a. Vision problems? Y / N
 - i. Wear contacts, eyeglasses or protective eye wear? (Circle which type.) Y / N
- b. Hearing loss or problems? Y / N
 - i. Wear hearing aids or implants? Y / N
- c. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y / N

Explain all "yes" answers here (include relevant dates):

5. Have you ever had, or do you currently have, any of the following NEUROMUSCULAR/ORTHOPEDIC conditions:

- a. Numbness, a "burner", "stinger" or pinched nerve? Y / N
- b. Dislocated joint(s)? Y / N
- c. Fracture(s), stress fracture(s), or broken bone(s)? Y / N

Explain all "yes" answers here (include relevant dates):

6. Have you ever had or do you currently have any of the following GENERAL OR EXERCISE RELATED conditions:

- | | |
|---|-------|
| a. Difficulty breathing? | Y / N |
| i. During exercise? | Y / N |
| ii. Exercise-induced asthma? | Y / N |
| 1. Controlled with medication? (specify _____) | Y / N |
| 2. Experience dizziness, passing out or fainting? | Y / N |
| b. Heat-related problems (dehydration, dizziness, fatigue, headache)? | Y / N |
| i. Heat exhaustion? | Y / N |
| ii. Heat stroke? | Y / N |
| iii. Muscle cramps? | Y / N |

Explain all "yes" answers here (include relevant dates):

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Signature, Parent/Guardian or Student Age 18 or older

Date of Signature

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

PHYSICAL EXAMINATION FORM
Part B: Physical Evaluation Form

-FINDINGS OF PHYSICAL EVALUATION

Height _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____ bpm
 Vision: R 20/_____ L 20/_____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/ Neck	YES	
Eyes/ Sclera/ Pupils	YES	
Ears	YES	
Nose/ Mouth/ Throat	YES	
Lymph Glands	YES	
Cardio Vascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No change
		Squatting makes it: Louder Softer No change
		Valsalva makes it: Louder Softer No change
Lungs: Auscultation/ Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Neck/ Back/ Spine:	YES	
Range of motion	YES	
Scoliosis	ABSENT	
Upper Extremities:(ROM. Strength, Stability)	YES	
Lower Extremities :(ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Evidence of Marfan Syndrome	ABSENT	

Circle one of the following:

- A. Student is cleared for participation in **all** sports without restriction
- B. Student is **withheld clearance** for participation in any sport until evaluation / treatment of:

 Physician Signature Print Name Date: _____

Address: _____ Phone Number: _____

This form must be filled out completely and returned to the Athletic Office before any athlete will be allowed to participate in intercollegiate sports at Central Christian College.