SAM HOUSTON BEARKATS

# PHYSICAL EXAMINATION FORM

Name_____ Date of Birth_____

Classification_____ Weight_____ Height _____ Pulse_____ BP_____/_____ (_____/_____, _____/_____)

Vision R 20/_____ L 20/_____ Corrected Y N Pupils: Equal_____ Unequal_____

| Follow-Up Questions on More Sensitive Issues | Yes | No |
|---|---|---|
| 1. Have you ever tried cigarette smoking, even 1 or 2 puffs? | ☐ | ☐ |
| 2. Do you currently smoke? | ☐ | ☐ |
| 3. During the past 30 days, did you use chewing tobacco, snuff, or dip? | ☐ | ☐ |
| 4. During the past 30 days, have you had at least 1 drink of alcohol? | ☐ | ☐ |
| 5. Have you ever taken steroid pills or shots without a doctor's prescription? | ☐ | ☐ |
| 6. Have you ever taken any supplements to help you gain or lose weight or improve your performance? | ☐ | ☐ |

Notes:_____

| MEDICAL | NORMAL | ABNORMAL FINDINGS | INITIALS |
|---|---|---|---|
| Appearance | | | |
| Eyes/ears/nose/throat | | | |
| Hearing | | | |
| Lymph nodes | | | |
| Heart | | | |
| Murmurs | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary (males only) | | | |
| Skin | | | |
| Urine Analysis | | | |
| Sickle Cell Trait Screening | | | |

Notes:_____

Name of physician (print/type)_____ Date_____

Address_____ Phone_____

Signature of physician_____, MD or DO

| MUSCULOSKELETAL | NORMAL | ABNORMAL FINDINGS | INITIALS |
|---|---|---|---|
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hand/fingers | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot/toes | | | |

Notes:_____

_____

Name of physician (print/type)_____ Date_____

Address_____ Phone_____

Signature of physician_____, MD or DO

**MEDICAL HISTORY FORM**

Date of Exam_____

Name _____ Sex _____ Age_____ Date of Birth_____

Classification _____ Sport (s)_____

Huntsville Address_____ Home/Cell #_____

Permanent Home Address_____

***In case of emergency, contact: Parent(s)/Guardian***

Name_____ Relationship_____ Phone #_____

**Explain all "yes" answers below.**
**Circle questions if you don't know the answers.**

| | Yes | No |
|---|---|---|
| 1 Have you had a medical illness or injury since your last check up or sports physical? | ☐ | ☐ |
| 2. Do you have an ongoing or chronic illness? | ☐ | ☐ |
| 3. Have you ever been hospitalized overnight? | ☐ | ☐ |
| 4. Are you currently taking any prescription or nonprescription (over-the-counter) medicine or pills? | ☐ | ☐ |
| 5. Do you have allergies to medicines, pollens, foods, or stinging insects? | ☐ | ☐ |
| 6. Have you ever passed out or nearly passed out DURING exercise? | ☐ | ☐ |
| 7. Have you ever passed out or nearly passed out AFTER exercise? | ☐ | ☐ |
| 8. Have you ever had discomfort, pain, or pressure in your chest during exercise? | ☐ | ☐ |
| 9. Does your heart race or skip beats during exercise? | ☐ | ☐ |
| 10. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ High cholesterol ☐ A heart murmur ☐ A heart infection | ☐ | ☐ |
| 11. Has a doctor ever ordered a test for your heart? (for example, EKG, echocardiogram) | ☐ | ☐ |
| 12. Has anyone in your family died for no apparent reason? | ☐ | ☐ |
| 13. Does anyone in your family have a heart problem? | ☐ | ☐ |
| 14. Has any family member or relative died of heart problems or of sudden death before age 50? | ☐ | ☐ |
| 15. Does anyone in your family have Marfan Syndrome? | ☐ | ☐ |
| 16. Have you had surgery? | ☐ | ☐ |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below: | ☐ | ☐ |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | ☐ | ☐ |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, circle below: | ☐ | ☐ |

Head Neck Shoulder Upper arm Elbow Forearm Hand/ fingers Chest

Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ toes

| | Yes | No |
|---|---|---|
| 20. Have you ever had a stress fracture? | ☐ | ☐ |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | ☐ | ☐ |
| 22. Do you regularly use a brace or assistive device? | ☐ | ☐ |
| 23. Has a doctor ever told you that you have asthma or allergies? | ☐ | ☐ |
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 25. Is there anyone in your family who has asthma? | ☐ | ☐ |
| 26. Have you ever used an inhaler or taken asthma medicine? | ☐ | ☐ |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | ☐ | ☐ |
| 28. Have you had infectious mononucleosis (mono) within the last month? | ☐ | ☐ |
| 29. Do you have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| 30. Have you had a herpes skin infection? | ☐ | ☐ |
| 31. Have you ever had a head injury or concussion? | ☐ | ☐ |
| 32. Have you been hit in the head and been confused or lost your memory? | ☐ | ☐ |
| 33. Have you ever had a seizure? | ☐ | ☐ |
| 34. Do you have headaches with exercise? | ☐ | ☐ |
| 35. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? | ☐ | ☐ |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill? | ☐ | ☐ |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | ☐ | ☐ |
| 39. Have you had any problems with your eyes or vision? | ☐ | ☐ |
| 40. Do you wear glasses or contact lenses? | ☐ | ☐ |
| 41. Do you wear protective gear, such as goggles or a face shield? | ☐ | ☐ |
| 42. Are you happy with your weight? | ☐ | ☐ |
| 43. Are you trying to gain or lose weight? | ☐ | ☐ |
| 44. Has anyone recommended you change your weight or eating habits? | ☐ | ☐ |
| 45. Do you limit or carefully control what you eat? | ☐ | ☐ |
| 46. Do you have any concerns that you would like to discuss with a doctor? | ☐ | ☐ |

**FEMALES ONLY**

| | | |
|---|---|---|
| 47. Have you ever had a menstrual period? | ☐ | ☐ |
| 48. How old were you when you had your first menstrual period? _____ | | |
| 49. How many periods have you had in the last 12 months?_____ | | |

Explain any "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 the athlete**_____ **Date**_____

**Signature of parent/guardian**_____ **Date**_____