



# Heritage Academy Sports Physical

Student: \_\_\_\_\_

This portion is to be filled out by the patient and their parents prior to seeing the physician.

Y	N	Yes = Y	No = N
		Have you had a medical illness or injury since your last check-up or sports physical?	
		Do you have an ongoing or chronic illness?	
(Explain Yes Answers)			
		Have you ever been hospitalized overnight?	
		Have you ever had surgery?	
(Explain Yes Answers)			
		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?	
(List medications, herbal and nutritional supplements, vitamins)			
		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?	
(Explain Yes Answers)			
		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?	
(Explain Yes Answers)			
		Do you have any current skin problem (for example, itching, rashes, acne, warts, fungus, or blisters)?	
		Do you want to weigh more or less than you do now?	
		Do you lose weight regularly to meet weight requirements of your sport?	
		Do you feel stressed out?	
(Explain Yes Answers)			
Record the dates of your most recent immunizations (shots):			
		Tetanus _____	Measles _____
		Hepatitis B _____	Chickenpox _____

  

Y	N	Yes = Y	No = N
		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?	
(Explain Yes Answers)			
		Have you ever become ill from exercising in the heat?	
		Do you cough, wheeze, or have trouble breathing during or after activity?	
		Do you suffer from asthma?	
		Do you have seasonal allergies that require medical treatment?	
(Explain Yes Answers)			
		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 rolls, foot orthotics, retainer on your teeth, hearing aids)?	
(Explain Yes Answers)			
		Have you had any problems with your eyes or vision?	
		Do you wear glasses, contacts, or protective eyewear?	
(Explain Yes Answers)			
		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 problems with pain or swelling in muscles, tendons, bones, or joints?	
<i>If yes, Circle the appropriate boxes and explain below:</i>			
		Head	Elbow
		Neck	Forearm
		Back	Wrist
		Chest	Hand
		Shoulder	Finger
		Upper Arm	Foot
		Hip	Thigh
		Knee	Shin/Calf
		Ankle	Foot
<b>FEMALES ONLY</b>			
When was your last menstrual period? _____			
How old were you when you had your first 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 12 months? _____			

**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: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_**

### Physician Section

Sports athlete will participate in:

- Basketball    Soccer    Track    Volleyball
- Other: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Body fat (optional) \_\_\_ %   Pulse \_\_\_\_\_   BP \_\_\_\_\_/\_\_\_\_\_(\_\_\_\_\_/\_\_\_\_\_,\_\_\_\_\_/\_\_\_\_\_)

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_   Corrected Y / N   Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

MEDICAL	Normal	Abnormal
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		

MUSCULOSKETAL	Normal	Abnormal
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wristband		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

**Describe Abnormal Findings:**

#### CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
\_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date: \_\_\_\_\_

Signature of physician \_\_\_\_\_, (MD/DO/ARNP/Chiropractor)

Address \_\_\_\_\_ Phone: \_\_\_\_\_