

Coe-Brown Northwood Academy Pre-Participation Physical Examination

HEALTH HISTORY

Name		Sex	Age	Date of Birth
Grade	School		Sport(s)	
Home Address			Home Phone	
Personal Physician			Physician Phone	
In case of emergency, contact:				
Relationship		Phone(H)	Phone(W)	Phone(C)

Please answer all questions. Explain "Yes" answers below. Circle questions you do not know the answer to.

	YES	NO		YES	NO																
1. Has a doctor ever denied your participation in sports for any reason?			28. Do you have any rashes, pressure sores, or other skin problems?																		
2. Do you have an ongoing medical condition (like diabetes or asthma)?			29. Have you had a skin infection?																		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medication or pills?			30. Have you ever had a head injury or concussion?																		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?			31. Have you been hit in the head and been confused or lost your memory?																		
5. Have you ever passed out or nearly passed out DURING exercise?			32. Have you ever had a seizure?																		
6. Have you ever passed out or nearly passed out AFTER exercise?			33. Do you have headaches with exercise?																		
7. Does your heart race or skip beats during exercise?			34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?																		
8. Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection			35. Have you ever been unable to move your arms or legs after being hit or falling?																		
9. Has a doctor ever ordered a test for your heart? (i.e., ECG, echocardiogram)			36. When exercising in the heat, do you have severe muscle cramps or become ill?																		
10. Has anyone in your family died for no apparent reason?			37. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?																		
11. Does anyone in your family have a heart problem?			38. Have you had any problems with your eyes or vision?																		
12. Has any family member or relative died of heart problems or of sudden death before age 50?			39. Do you wear glasses or contact lenses?																		
13. Does anyone in your family have Marfan syndrome?			40. Do you wear protective eyewear, such as goggles or a face shield?																		
14. Have you ever spent the night in a hospital?			41. Are you happy with your weight?																		
15. Have you ever had surgery?			42. Are you trying to gain or lose weight?																		
16. 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:			43. Has anyone recommended you change your weight or eating habits?																		
17. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:			44. Do you limit or carefully control what you eat?																		
18. 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:			45. Do you have any concerns that you would like to discuss with a doctor?																		
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Head</td> <td style="padding: 2px;">Neck</td> <td style="padding: 2px;">Shoulder</td> <td style="padding: 2px;">Upper Arm</td> <td style="padding: 2px;">Elbow</td> <td style="padding: 2px;">Forearm</td> <td style="padding: 2px;">Hand/ Fingers</td> <td style="padding: 2px;">Chest</td> </tr> <tr> <td style="padding: 2px;">Upper Back</td> <td style="padding: 2px;">Lower Back</td> <td style="padding: 2px;">Hip</td> <td style="padding: 2px;">Thigh</td> <td style="padding: 2px;">Knee</td> <td style="padding: 2px;">Calf/ Shin</td> <td style="padding: 2px;">Ankle</td> <td style="padding: 2px;">Foot/ Toes</td> </tr> </table>	Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest	Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes			FEMALES ONLY		
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest														
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes														
19. Have you ever had a stress fracture?			46. Have you ever had a menstrual period?																		
20. Have you been told that you have or have you had an xray for atlantoaxial (neck) instability?			47. How old were you when you had your first menstrual period?																		
21. Do you regularly use a brace or assistive device?			48. How many periods have you had in the last 12 months?																		
22. Has a doctor ever told you that you have asthma or allergies?			Explain "Yes" answers here:																		
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?			_____																		
24. Is there anyone in your family who has asthma?			_____																		
25. Have you ever used an inhaler or taken asthma medicine?			_____																		
26. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?			_____																		
27. Have you had infectious mononucleosis (mono) within the last month?			_____																		

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: _____

Name			Date of Birth	
Height	Weight	Pulse		BP
Vision: Right: 20/		Left: 20/		Corrected: Yes No Pupils: Equal <input type="checkbox"/> Unequal <input type="checkbox"/>

Allergies: _____

Other Health Concerns: _____

PHYSICAL EXAMINATION

DATE OF EXAM:

MEDICAL	Normal	Abnormal Findings	Initials
Appearance			
Eyes/ Ears/ Nose/ Throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (Males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/ Arm			
Elbow/ Forearm			
Wrist/ Hand/ Fingers			
Hip/ Thigh			
Knee			
Leg/ Ankle			
Foot/ Toes			

Notes: _____

CLEARANCE

- Cleared without restriction to participate in athletics.
 - Cleared with recommendations for further evaluation or treatment for: _____
 - Not cleared for: _____ Reason: _____
- Recommendations: _____

Signature of Physician/Nurse Practitioner: _____ Date: _____

Name of Physician/Nurse Practitioner (print): _____

Address _____ Phone: _____

****Primary care physicians, please include a copy or verification that this student's immunizations are complete and up to date.**