DALTON STATE COLLEGE
DEPARTMENT OF SPORTS MEDICINE

INITIAL HEALTH QUESTIONAIRE

HAS ANY RELATIVE EVER HAD? Please mark and "X" to all those that apply.

CONDITION	X	REALTION		CONDITION	X	RELATION
CANCER				STROKE		
HIGH BLOOD PRESSURE				EPILEPSY		
DIABETES				MENTAL HEALTH		
HEART DISEASE				SUDDEN DEATH		

PERSONAL MEDICAL HISTORY HAVE YOU EVER HAD? Please mark an "X" to all those that apply.

Condition	X	Condition	X	Condition	X
Hepatitis A/B/C/D		Eczema/ Psoriasis		Asthma/ Exercise Induced Asthma	
Mental Illness Treatment		Migraine Headaches		Appendicitis	
Epilepsy/ Seizures		Tuberculosis		Injury to Spleen OR Kidney	
Diabetes I or II		Cancer		Anemia	
Anorexia		Neuritis		Colitis of other bowel disease	
Bulimia		Neuralgia		Hemorrhoids or any rectal disease	
Pneumonia		Gonorrhea		Jaundice	
Pleurisy		Syphilis		Gallbladder Disease	
Rheumatic Fever		Arthritis		Hernia	
Heart Disease		Rheumatism		Hives	

Have you ever been disqualified for a heart problem? (Y/N)	If yes, please Explain:
Have you ever had a blood or plasma transfusion? (Y/N)	If yes, please Explain:
Have you ever been hospitalized for an illness? (Y/N)	If yes, please Explain:
Have **you** been diagnosed with Sickle Cell Disease? (Y/N) If yes, Explain any problems related to Sickle Cell Disease:	
Has **anyone in your family** been diagnosed with Sickle Cell Disease? (Y/N)	
Have you had and disease not mentioned above? (Y/N)	

Current Medical History: HAVE YOU HAD IN THE PAST YEAR Please mark an "X" to all those that apply

HAVE YOU HAD IN THE PAST YEAR?	X		HAVE YOU HAD IN THE PAST YEAR?	X
Frequent or severe headaches			Excessive shortness of breath with activity	
Fainting spells/ Unconscious spells			Passed out with activity for any reason	
Blurred Vision/ Double vision			Ever been told you have a heart murmur	
Spot before eyes			Purple lips or fingers	
Pain behind eyes			Racing or skipping of heart	
Earaches /Discharge from ears			High or low blood pressure	
Ringing in ears			Wake up at night short of breath	
Decreased hearing/ear Problems			Recurrent stomach pains/Abdominal cramping	
Recurrent nose bleeds			Nausea or vomiting	
Recurrent head colds			Pain/blood with urination	

Sinus trouble/ hay fever			Recurrent back pains	
Persistent hoarseness			Recurrent joint pain	
Difficulty swallowing			Swelling of joints /Redness /heat of any joint	
Enlarged glands			Tingling or weakness of hands or feet	
Recurrent sore throat			Loss or change in sensation of hands/feet	
Recurrent sores in mouth			Trembling in any extremity	
Soreness or bleeding gums with brushing			Muscle Spasms	
Chest pain			Tiredness with no apparent reason	
Coughed up blood			Dryness of skin or skin rash	
Night sweats			Easy bruising	
Chronic or frequent cough			Inability to stand cold/heat	

Please explain any "X" from above:		
Do you wear glasses? (Y/N)	Date they last checked?	
Do you wear contacts? (Y/N)	During competition? (Y/N)	What type? (Hard/ Soft)

CURRENT MEDICATIONS: Please mark an "X" to all that apply										
Accutane		Zoloft		Albuterol		Amoxicillin		Zantac		Atrovent
Benadryl		Claritin		Lithium		Keflex		Ventolin		Tetracycline
Minocycline		Paxil		Proventil		Ritalin		Xanax		Sulfa drugs

Please list all medications that you are taking, not identified above:			
Do you use an inhaler? (Y/N)	If yes, why and what kind?		
Do you take prescription anti-inflammatories? (Y/N)	If yes, why and what kind?		
Approximate number of alcohol beverage consumed per week:			
Chew Tobacco? (Y/N)	Smoke (Y/N)	How many packs?	Number of years smoking?
Have you ever taken insulin of tablets for diabetes?(Y/N)		If yes, which one?	
Have you ever taken hormone tablets or injections?(Y/N)		If yes, explain on the line below:	

ALLERGIES: List any allergies to:

Medications:	Reaction:
Food:	Reaction:
Insects:	Reaction:

NEUROLOGICAL

Do you have or have you ever had the following?	**If yes, please explain:**
Skull Fracture?	
Concussion How many concussions total?	
Last concussion was: How long did that concussion last?	
Unconscious: How long did unconsciousness last?	
Neck Injury What spinal level?	
Pinched Nerve (Burner or Stinger)Left/ right/ both?	

Condition	X	Condition	X
Anxiety/Stress		Hallucinations	
Depression		Sleep Disturbances?	
Mood Swings		ADD/ADHD/Hyperactivity	
Have you been treated for a drug habit? (Y/N)Please explain:			

BODY WEIGHT			
What is your current body weight?		Most you have ever weighed?	
How much did you weigh a year ago?		Least you have weighed in 5 years?	

WOMEN ONLY

Regular Cycles? (Y/N/Varies)	Longest time between menstrual period?
Number of menstrual period in the last 12 months?	Are you pregnant? (Y/N)
Date of last Pap Test	Result of last pap test?
Do you take birth control? If yes, what kind and how long?	
MEN ONLY	
Do you experience any discharge from penis? (Y/N)	

DIAGNOSTIC TESTING: Please mark an "X" to all that apply.

X-RAYS ON:	X	If yes, please explain		X-RAYS ON:	X	If yes, please explain
Extremities				Chest		
Gall Bladder				Back		
Stomach or colon				Other		

A DIAGNOTIC TEST USING:				DIAGNOTIC TEST		
EKG				CT Scan		
Echocardiogram				MRI		

SURGICAL HISTORY: List all surgery in the past 5 years

Type of Surgery	Body Part	Date of Surgery
Have you ever been advised to have a surgery that was not done? (Y/N)		Loss of paired organ? (Y/N)
If yes, please explain:		

ANKLE/ FOOT

- Have you ever had an ankle and/ or foot injury?YES____NO ___ Right Left Both
  - If yes, what were the injury/ injuries? _____
- Have you ever had an Achilles tendon injury? YES____NO ___ If yes, which Achilles?_____
- Have you ever had plantar fasciitis? YES____ NO ___ Right Left Both
- Have you ever had a stress fracture? YES____ NO ___ Right Left Both
- Any other injury not mentioned?

KNEE

- Have you ever had a significant knee injury? YES__NO ____ If yes, which knee? Right Left Both
  - If yes, when? _____If yes, did the injury require surgery? YES____ NO ____
  - If surgery was required, please give the physician's name, address and phone # below
- Have you ever suffered from Osgood Slaughter's Disease? YES____ NO ____

·Have you ever had tendonitis? If so where?

·Have you ever dislocated your patella (knee cap)? YES____ NO ___ Right Left Both

·Any other injury not mentioned?

SHOULDER

· Have you ever had a significant shoulder injury? YES____ NO ____Right Left Both

If yes, when? _____ If yes, did the injury require surgery? YES____ NO ____

If yes, is this your throwing or shooting shoulder? YES____ NO ____

If yes, did the injury require surgery? YES____ NO ____

If surgery was required, please give the physician's name, address and phone # below

·Have you been told you have shoulder instability? YES____ NO ____

·Have you ever separated your AC joint? YES____ NO ____ Right Left Both

Any other injury not mentioned?

Are you on a strengthening program for your shoulder? YES____ NO ____

ELBOW

·Have you ever had a significant elbow injury? YES____ NO ____

If yes, which elbow? Right Left Both If yes, when? _____

If yes, is this your throwing or shooting elbow? YES____ NO ____

If yes, did the injury require surgery? YES____ NO ____

If surgery was required, please give the physician's name address and phone # below

FRACTURES, DISLOCATIONS, and PULLED MUSCLES

·Have you ever had a fractured bone? YES____ NO____

If yes, which bone(s)? _____If yes, when? _____

If yes, was it a stress or traumatic fracture? _____

·Do you have any plates, screws, or pins in bones? YES____ NO ____

If yes, which bone(s)? _____ If yes, when? _____

·Have you ever dislocated a joint? YES____ NO ____ If yes, which joint? _____When? _____

·Have you ever had a badly pulled muscle? Y ES____ NO ____

If yes, explain _____ If yes, did it re-occur? _____

FURTHER INFORMATION

Anything not covered by the above questions or further explanation needed:

_____

_____

I, _____, confirm that, to the best of my knowledge, that all the demographic, medical and insurance information reported in this document is accurate. *I understand that any incorrect or undisclosed information may compromise my level of medical care.*

_____

Athletes Signature (if over 18 years of age) Date

_____

Parent/Guardian Signature (if athlete is under 18) Date

Athlete Name DOB / /

PHYSICAL EXAM

Height _____ Weight _____ Calculated BMI:____ Blood Pressure _____/_____ Respiration _____Pulse _____

Vision R 20/_____ L 20/_____ Corrected Y N

Medical	Normal	Abnormal findings
General Appearance (Marfan stigmata (such as kyphoscoliosis, long fingers, arm span >height), malnourished, anxious?)		
Eyes/ears/nose/throat (High arched palate, oropharynx clear, salivary		
gland hyperplasia, tympanic membranes normal lymph nodes, thyroid?)		
Heart (auscultate standing, supine, +/- Valsalva, pulses equal?) (Murmurs, rate and rhythm, PMI, pectus carinum/excavatum?)		
Lungs (CTAB, wheezes, rhonchi, rhales, normal effort?)		
Abdomen (soft, non-tender, non-distended, no HSM, active bowel sounds?)		
Genitourinary (males only) (testicular masses, lesions, swelling, hernias?)		
Skin (lesions, blisters, dry scaly plaques, scalp clear?)		
Neuro (PERRLA/EOMI, CN II-XII intact, moves all 4 extremities, reflexes?)		
Muscular Skeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional: Duck-walk, single leg hop		

A Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
B Consider GU exam if in private setting. Having third party present is recommended.
C Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports _____

Reason/Recommendation _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____Date_____Address_____ Phone _____

Signature of physician _____,MD or DO