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
1. Has a doctor ever denied your participation in sports for any reason?		
2. Do you have an ongoing medical condition (like diabetes or asthma)?		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medication or pills?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		
5. Have you ever passed out or nearly passed out DURING exercise?		
6. Have you ever passed out or nearly passed out AFTER exercise?		
7. Does your heart race or skip beats during exercise?		
8. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
9. Has a doctor ever ordered a test for your heart? (i.e., ECG, echocardiogram)		
10. Has anyone in your family died for no apparent reason?		
11. Does anyone in your family have a heart problem?		
12. Has any family member or relative died of heart problems or of sudden death before age 50?		
13. Does anyone in your family have Marfan syndrome?		
14. Have you ever spent the night in a hospital?		
15. Have you ever had surgery?		
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:		
17. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		
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:		

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?		
20. Have you been told that you have or have you had an xray for atlantoaxial (neck) instability?		
21. Do you regularly use a brace or assistive device?		
22. Has a doctor ever told you that you have asthma or allergies?		
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?		

	YES	NO
28. Do you have any rashes, pressure sores, or other skin problems?		
29. Have you had a skin infection?		
30. Have you ever had a head injury or concussion?		
31. Have you been hit in the head and been confused or lost your memory?		
32. Have you ever had a seizure?		
33. Do you have headaches with exercise?		
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
35. Have you ever been unable to move your arms or legs after being hit or falling?		
36. When exercising in the heat, do you have severe muscle cramps or become ill?		
37. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
38. Have you had any problems with your eyes or vision?		
39. Do you wear glasses or contact lenses?		
40. Do you wear protective eyewear, such as goggles or a face shield?		
41. Are you happy with your weight?		
42. Are you trying to gain or lose weight?		
43. Has anyone recommended you change your weight or eating habits?		
44. Do you limit or carefully control what you eat?		
45. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
46. Have you ever had a menstrual period?		
47. How old were you when you had your first menstrual period?		
48. How many periods have you had in the last 12 months?		

Explain "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 Athlete: _____ Signature of Parent/Guardian: _____ Date: _____

Name			Date of Birth
Height	Weight	Pulse	BP
Vision: Right: 20/ Left: 20/		Corrected: Yes No	Pupils: Equal ☐ Unequal ☐

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.**