

BAKER UNIVERSITY SPORTS PARTICIPATION HISTORY & PHYSICAL

Due Aug. 1, 2011

Name _____ Date _____

Date of Birth _____ Sport _____

This Section is to be filled out by Athlete

I. Put an "X" in the blank if you have now or have ever had the following:

- | | | | | |
|-------------------------------------|--------------------------------------|---|---|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> High/Low Blood Sugar | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Measles | <input type="checkbox"/> Abnormal Heart Beat | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Birth Deformities | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Heat Exhaustion/Stroke | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney Disease |

II. Put an "X" in the blank if you have ever had an illness/injury involving the following:

- | | | | | | |
|--------------------------------|--------------------------------|--------------------------------|-------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Calf | <input type="checkbox"/> Hand | <input type="checkbox"/> Hip | <input type="checkbox"/> Thigh | <input type="checkbox"/> Abdomen/Pelvis |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Elbow | <input type="checkbox"/> Head | <input type="checkbox"/> Knee | <input type="checkbox"/> Wrist | <input type="checkbox"/> Chest/Breast |
| <input type="checkbox"/> Back | <input type="checkbox"/> Foot | <input type="checkbox"/> Heart | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder | |

III. Females Only: Menstrual History:

Age of Onset Interval Between Periods Duration

IV. Put an "X" if you have a family history of:

- Sudden Death at a Young Age
- Syncope (Passing Out)
- Sickle Cell Disease or Trait
- High Blood Pressure

VI. Circle the appropriate answer to the following.

- | | |
|-----------|--|
| Yes or No | 1. Have you ever been "knocked out" or experienced a concussion? If yes, how many times? ____ |
| Yes or No | 2. Have you ever been hospitalized due to a concussion? |
| Yes or No | 3. Have you ever had a "Burner" or "Stinger"? If yes, how many? _____ |
| Yes or No | 4. Have you ever passed out? |
| Yes or No | 5. Have you ever been withheld from participating in a sport for medical reasons? |
| Yes or No | 6. Do you wear Glasses or Contacts? While playing? Yes or No |
| Yes or No | 7. Do you have any dead, missing, chipped, or broken teeth? |
| Yes or No | 8. Do you wear dental appliances? |
| Yes or No | 9. Have you had any injuries to the neck or back nerves, vertebrae (bones) or vertebral discs? |
| Yes or No | 10. Have you had any surgery on your neck or back? |
| Yes or No | 11. Have you had any fractures within the last two years? |
| Yes or No | 12. Have you had surgery within the last two years? |
| Yes or No | 13. Are you taking any medication? |
| Yes or No | 14. Are you allergic to any medication? |

Explain any "X" or "Yes" answers in the space below or on the back of the page.

SIGNATURE

DATE

PHYSICAL EXAMINATION (To be administered by MD or DO)

Name _____ Sport _____ Height _____ Weight _____ Date _____

Immunizations: Tetanus date within last 5 yrs _____ TB (date) _____

MMR dates _____ Hepatitis B dates _____ Meningitis (date) _____
 (Mandatory)

Normal	Abnormal	General Medical Information
		Eyes: Vision
		Ears: Hearing, Canals, Drums
		Nose: Septum, Obstructions
		Mouth: Membranes, Throat, Tonsils, Teeth
		Abdomen/Pelvis: Viscera Scars, Hernia
		Heart: Chest: Lungs:
		Pulse: Blood Pressure:

Cardiac Health

Rhythm: _____ Marfanoid? Yes / No
 Murmurs: Supine: _____
 Standing: _____
 Pulses: Radial: R _____ L _____ Femoral: R _____ L _____
 O-Absent D-Diminished N-Normal H-Hyperactive

Normal	Abnormal	Musculoskeletal Exam
		Spine
		Shoulders: Left: Right:
		Elbows: Left: Right:
		Wrists: Left: Right:
		Hands: Left: Right:
		Hips: Left: Right:
		Thighs: Left: Right:
		Knees: Left: Right:
		Ankles: Left: Right:
		Feet: Left: Right:

Athletic participation approved without limitation: Yes / No
 If no, specify participation limitations: _____
 Specify actions needed for clearance: _____

Physician's Name: _____ Signature _____

Address: _____ City _____ State _____ ZIP _____

Telephone Number: _____ Fax Number: _____