UCSD SPORTS PARTICIPATION HEALTH RECORD – PHYSICAL EXAMINATION

NAME _____ DATE _____ AGE _____ BIRTHDATE_____

Height _____ Vision: R _____/_____ corrected _____, uncorrected _____

Weight _____ L _____/_____ corrected _____, uncorrected _____

Pulse _____ BMI_____ Blood Pressure _____ **SPORT**_____

		Normal	Abnormal Findings
ORTHOPEDIC EXAM	Musculoskeletal: ROM, strength, etc.		
	a. neck		
	b. spine		
	c. shoulders		
	d. arms/hands		
	e. hips		
	f. thighs		
	g. knees		
	h. ankles		
	i. feet		
	Neuromuscular		

Comments re: Abnormal Findings _____

_____

PARTICIPATION RECOMMENDATIONS:

1. No participation in:_____
2. Limited participation in:_____
3. Requires:_____
4. Full participation in:_____

Orthopedic Examiner Signature:_____

Orthopedic Examiner Name (print):_____

			Normal	Abnormal Findings
SPORTS MEDICINE FAMILY PRACTICE PHYSICIAN	Eyes			
	Ears, Nose, Throat			
	Mouth & Teeth			
	Neck			
	Cardiovascular	Standing or Sitting		
		Lying		
		Valsalva		
	Chest and Lungs			
	Abdomen			
	Skin			
	[redacted]			

Comments re: Abnormal Findings _____

_____

ONLINE MEDICAL HISTORY SCREENING FORM WAS REVIEWED: check here ☐ Comments:_____

_____

_____

PARTICIPATION RECOMMENDATIONS:

1. No participation in:_____
2. Limited participation in:_____
3. Requires:_____

_____

4. Full participation in:_____

OVERALL CLEARANCE:

FULL ☐ LIMTED ☐ See above sections for comments NO PARTICIPATION ☐

Physician's Signature:_____

Physician's Name (print):_____

Medical History Questionnaire

INJURIES

Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or a game?

Yes___ No___

If yes, please explain.

Have you ever had any broken or fractured bones, or dislocated joints?

Yes___ No___

If yes, please explain.

Have you ever had a bone/joint injury that required x-rays, MRI, CT scan, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches (other than ones already listed)?

Yes___ No___

If yes, please explain.

Do any of your joints become painful, swollen, feel warm, or look red?

Yes___ No___

If yes, please explain.

Do you have any history of juvenile arthritis or connective tissue disease?

Yes___ No___

SURGERIES

Have you ever had surgery (other than surgeries already listed)?

Yes___ No___

If yes, please explain.

NEUROLOGICAL ISSUES

Have you ever had a head injury or been diagnosed with a concussion?

Yes___ No___

How many?

When was the last one?

Have you ever had a loss of consciousness?

Yes___ No___

If yes, please explain.

Have you ever had a seizure (e.g. epilepsy)?

Yes___ No___

When was the last one?

Do you have frequent or severe headaches (including migraines)?

Yes___ No___

Do you have headaches with exercise?

Yes___ No___

Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?

Yes___ No___

Have you ever been unable to move your arms or legs after being hit or falling?

Yes___ No___

Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?

Yes___ No___

SIGNIFICANT HEALTH ISSUES

Has a doctor ever denied or restricted your participation in sports for any reason?

Yes___ No___

If yes, please explain.

Have you ever been hospitalized overnight for reasons other than surgery?

Yes___ No___

If yes, please explain.

Were you born without or are you missing a kidney, and eye, a testicle, or any other organ?

Yes___ No___

If yes, please explain.

GENERAL MEDICAL ISSUES

Are there any current prescription medicines or over-the-counter medicines that you take regularly (also include any vitamins, supplements, or herbs)?

Yes___ No___

If yes, please explain.

Do you have any allergies to medicines?

Yes___ No___

If yes, what medications?

Do you have any severe allergies to food or insect stings?

Yes___ No___

If yes, please explain.

Do you cough, wheeze, or have excessive shortness of breath during or after exercise?

Yes___ No___

Do you have asthma?

Yes___ No___

Is there anyone in your family who has asthma?

Yes___ No___

Have you ever had any rash or hives develop during or after exercise?

Yes___ No___

Do you have any current skin problems (e.g. athlete's foot, ringworm, impetigo)?

Yes___ No___

Have you ever had a herpes skin infection or MRSA skin infection?

Yes___ No___

Have you had infectious mononucleosis (mono) within the past month?

Yes___ No___

Have you ever been diagnosed with tuberculosis, hepatitis, or kidney disease?

Yes___ No___

When exercising in the heat, do you have severe muscle cramps or become ill?

Yes___ No___

Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (e.g. pads, braces, mouthguards, etc.)?

Yes___ No___

Have you ever had a detached retina or any severe eye trauma?

Yes___ No___

Do you wear contacts or glasses?

Yes___ No___

Have you ever had a hernia?

Yes___ No___

Has anyone recommended you change your weight or eating habits?

Yes___ No___

Do you have any history of anorexia or bulimia?

Yes___ No___

Do you have a history of bleeding disorders such as hemophilia, Von Willebrand disease, or other factor deficiencies?

Yes___ No___

Have you ever been tested/diagnosed with Sickle Cell Trait? Has anyone in your family been diagnosed with this trait?

Yes___ No___

Are you currently under the care of a physician for any ongoing medical problems (e.g. anemia, asthma, diabetes, thyroid disorder, etc.)?

Yes___ No___

If yes, please explain.

Do you have any concerns (physical or mental health) that you would like to discuss with one of the SC athletic trainers?

Yes___ No___

CARDIOLOGY SCREENING

Have you ever passed out, or nearly passed out, during or after exercise?

Yes___ No___

If yes, please explain.

Have you ever had discomfort, pain, or pressure in your chest during exercise?

Yes___ No___

If yes, please explain.

Does your heart race or skip beats during exercise?

Yes___ No___

Has a doctor ever told you that you have high blood pressure, heart murmur, high cholesterol, or heart infection?

Yes___ No___

If yes, please explain.

Has a doctor ever ordered a test for your heart (e.g. ECG/EKG, echocardiogram, stress test)?

Yes___ No___

If yes, please explain.

Has any family member/relative died of heart problems or had an unexpected or unexplained sudden death before age 50?

Yes___ No___

If yes, please explain.

Is there any family history of Marfan's syndrome, arrhythmogenic right ventricular cardiomyopathy, hypertrophic cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, catecholaminergic polymorphic ventricular tachycardia, or other heart problem?

Yes___ No___

If yes, please explain.

Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?

Yes___ No___

Has a physician ever denied or restricted your participation in sports for any heart problems?

Yes___ No___

If yes, please explain.

WOMEN'S HEALTH

Do you use a hormonal form of contraception, or other hormonal medication?

Yes___ No___

At what age was your first menstrual period?

How many menstrual periods have you had in the past 12 months?

What was the longest time between periods in the past 12 months?

FAMILY HISTORY

Has anyone in your immediate family ever had diabetes (high blood sugar), high blood pressure, high cholesterol?

Yes___ No___

Has anyone in your immediate family ever had a stroke?