

ALBRIGHT ATHLETICS

MEDICAL HISTORY & PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Revised 3/04

DATE: _____ / _____ / _____
Month Day Year

Athlete's Name: _____ Sports(s): _____
(Last) (First) (Middle) (Nickname)

Social Security No: _____ / _____ / _____ Date of Birth: _____ / _____ / _____
Month Day Year Age Sex Race

Classification: Fr. So. Jr. Sr. Red Shirt Sr.

e-Mail Address(es): _____

Local Apartment, Address, Dormitory, etc. _____ Local Phone: _____ Cell Phone: _____

I. Person to notify in case of an Emergency: _____ Relationship: _____		
Address: _____ <small>(City) (State) (Zip)</small>		
Home Phone: (_____) _____		Business Phone: (_____) _____
Cell Phone (_____) _____		e-Mail: _____

II. Father's Name: _____
Address: _____ <small>(City) (State) (Zip)</small>
e-Mail: _____
Home Phone: (_____) _____
Business Phone: (_____) _____
Cell Phone (_____) _____

III. Mother's Name: _____
Address: _____ <small>(City) (State) (Zip)</small>
e-Mail: _____
Home Phone: (_____) _____
Business Phone: (_____) _____
Cell Phone (_____) _____

IV. Orthopedic Physician _____
Address: _____ <small>(City) (State) (Zip)</small>
Business Phone: (_____) _____
e-Mail: _____

V. Name of family physicians: _____ Business Phone (_____) _____
Address: _____ <small>(City) (State) (Zip)</small>

VI. High School attended: _____ School Phone: (_____) _____
Address: _____ <small>(City) (State) (Zip)</small>
Coach's Name: _____ Athletic Trainer's Name: _____

VII. Junior College(s) / College(s) previously attended: _____ College Phone: (_____) _____
Address: _____ <small>(City) (State) (Zip)</small>
Coach's Name: _____ Athletic Trainer's Name: _____

A. FAMILY MEDICAL HISTORY: Has any blood relative ever had?

Cancer	YES	NO	Stroke	YES	NO	Alcoholism/Drug Abuse	YES	NO
Diabetes	YES	NO	Epilepsy/Seizures	YES	NO	Die suddenly before age 50 years	YES	NO
Heart Trouble	YES	NO	Mental Illness/Depression	YES	NO	Sickle Cell Trait/Disease	YES	NO
High Blood Pressure	YES	NO	Suicide	YES	NO	Bleeding Disorder/Blood Disease	YES	NO
Other, please explain:								

B. MEDICAL ILLNESS HISTORY: *NOTE: This information will be kept CONFIDENTIAL!!!

1. Have you ever had or do you now have any of the conditions below? If so, check yes. If not, check no.

2. If yes, put your age the condition occurred at in the appropriate box.

CHECK EACH ITEM	AGE	YES	NO	CHECK EACH ITEM	AGE	YES	NO	CHECK EACH ITEM	AGE	YES	NO
Car, Air, Motion, or Sea Sickness				Contact with Hepatitis B (HBV)				Palpitation or Pounding Heart			
Ear, Nose, or Throat Trouble				Contact with AIDS or HIV				Intestinal Trouble			
Asthma				Veneral Disease				Stomach Trouble			
Bronchitis				Jaundice				Frequent Indigestion			
Chronic Cough				Mononucleosis				Cancer			
Tuberculosis				Chronic Frequent Colds				Tumor/ Growth/ Cyst			
Swimmer's Ear				Kidney Trouble				Skin Trouble			
Inner Ear Infection				Kidney Stones				Rheumatism			
Fever Blisters				Bloody Urine				Pain/Pressure in Chest			
Mumps				Sugar in Urine				Shortness of Breath			
Rheumatic Fever				Urinary Tract Infection				Psychiatric Problems			
Scarlet Fever				Painful Urination				Gout			
Typhoid Fever				Frequent Urination				Excessive Worry			
Chicken Pox				Rectal Bleeding				Depression			
Small Pox				Herpes Virus				Nervous Trouble			
Whooping Cough				Hemorrhoids				Insomnia			
Goiter/Thyroid Disease				Peptic Ulcer				Neuritis			
Diphtheria				Gall Bladder Trouble				Convulsions/ Fits			
Polio				Appendicitis				Dizziness			
Sickle Cell Anemia				Gallstones				Paralysis			
3-Day Measles				Liver Trouble				Amnesia			
Malaria				Athletes Foot				Migraine Headaches			
Soaking Night Sweats				Jock Itch				Frequent Headaches			
Frequent Nightmares				Ringworm				Nausea/Vomiting			
Obesity				Lyme Disease				Heartburn			

C. GENERAL MEDICAL ALLERGIES: Please answer as to whether you are allergic to the following items?

Aspirin	YES	NO	Penicillin	YES	NO	Tetanus antitoxin or serums	YES	NO	Bee stings	YES	NO
Codeine	YES	NO	Erythromycin	YES	NO	Novocaine or other anesthetics	YES	NO	Fire ant bits	YES	NO
Sulfa Drugs	YES	NO	Ibuprofen	YES	NO	Hay Fever – dust/mold/pollen/grass	YES	NO	Wasps stings	YES	NO
Iodine	YES	NO	Acetaminophen	YES	NO	Oral Anti-inflamitories	YES	NO	Latex	YES	NO
1. Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here:										YES	NO
2. Have you ever had any reaction to Serum Drugs? If yes, please list the drugs and related details here:										YES	NO

D. GYNECOLOGICAL HISTORY: *ONLY FEMALES ANSWER THIS SECTION*****

CHECK YES OR NO FOR THE FOLLOWING & IF THE ANSWER IS YES, WRITE IN THE AGE AT WHICH THE CONDITION OCCURRED.

	Number	Date	Age	Yes	No	Age	Yes	No	Age
Number of Pregnancies									
Number of Births									
Abnormal Pap Smears									
Last Pap Smear									
Last Period									
Endometriosis									
Are currently taking Birth Control Pills?	YES	NO	If yes, what type are you taking?						

E. GENERAL MEDICAL INFORMATION: (CIRCLE THE CORRECT ANSWER)

1. Do you have a Heart Disease? If yes, please list any medications taken for this condition:	YES	NO	Heart Disorder? If yes, please list any medications taken for this condition:	YES	NO	Heart Murmur? If yes, please list any medications taken for this condition:	YES	NO				
2. Have you ever had one of the following tests performed for a heart condition?	Electrocardiogram (EKG)		YES	NO	Echocardiogram		YES	NO	Treadmill Stress Test	YES	NO	
3. During the past year (twelve months) have you had any type of problem with tolerance to exercise? If yes, please give a brief explanation.									YES	NO		
4. Do you have Hypertension (High Blood Pressure)?	YES	NO	Do you have Hypotension (Low Blood Pressure)?		YES	NO						
5. Please list any and all medications you take for High or Low Blood Pressure including the names, dosages, and how often you take them:												
6. Have you Passed Out or had Fainting Spells?	YES	NO	Did this occur with exertional activities?				YES	NO				
7. Have you ever had a Concussion? If yes, please list the number of times and severity of each below:										YES	NO	
8. Have you ever been hospitalized for any of the concussions you sustained?											YES	NO
9. Have you ever been knocked unconscious? If yes, please list the number of times and which ones you were hospitalized for?										YES	NO	
10. Have you ever had a Skull Fracture?	YES	NO	Double Vision?		YES	NO	Blurred Vision?				YES	NO
11. Are you a Diabetic or ever been treated for Diabetes? If yes, please list the age at which your diabetes began as well as any and all medications you take for this condition:										YES	NO	
12. Do you or have you ever had Anemia?	YES	NO	Sickle- cell anemia or trait?		YES	NO	Hypoglycemia (Low Blood Sugar)?				YES	NO
13. Do you have a vision defect in either one or both eyes and if yes, please specify below:										YES	NO	
14. Do you wear glasses?	YES	NO	Do you wear contact lenses?				YES	NO				
15. If yes, do you wear them during practice?	YES	NO	If yes, do you wear them during games?				YES	NO				
16. Have you ever had glaucoma?	YES	NO	Have you ever had retinal detachment?				YES	NO				
17. Do you have a hearing defect? If yes, please specify below and list any hearing aids worn:										YES	NO	
18. Do you wear any dental appliances?	YES	NO	If so, do you wear them during practice?				YES	NO				
19. If yes, circle the appropriate appliance: Corrective Braces. Permanent Bridge, Permanent Crown or Jacket, Removable Partial or Full Plate												
20. Do you have any severe tooth trouble, gum trouble, or dead teeth? If yes, please list details below:										YES	NO	
21. In the past 3 years have you had a Tetanus shot?	YES	NO	Toxoid shot?		YES	NO	Booster shot?		YES	NO		
22. Have you ever received the Hepatitis B (HBV) Vaccination?			YES	NO	If yes, have you received all three shots?				YES	NO		
23. In the past 12 months have you been treated for >>>	Mononucleosis ?		YES	NO	Pneumonia?		YES	NO	Infectious Virus?		YES	NO
24. Do you currently take any medicines or drugs? If yes, what medications or drugs are you taking, and for what reason?										YES	NO	
25. Have you ever had trouble with dehydration? (Excess loss of salt & water)						YES	NO	Heat Intolerance?		YES	NO	
26. Have you ever had Heat Cramps?			YES	NO	Heat Exhaustion?		YES	NO	Heat Stroke?		YES	NO
27. Have you ever suffered from or been diagnosed with Exercise Induced Asthma (EIA)? If yes, what medication(s) are you taking to control EIA?										YES	NO	
28. Have you ever had an internal injury? If yes, describe the nature of the injury and the body part(s) or organ(s) involved?										YES	NO	
29. Have you ever lost the full use of the following organs, either temporarily or permanently? (Hearing, Sight, Kidneys, Lungs, Testicles(male), Ovaries(female), other) If yes, please list the organ(s) and details regarding the loss, including the dates and treating physicians for each:										YES	NO	
30. Have you ever had surgery to repair or remove any organ? If yes, please list the organ(s) and details regarding the repair and/or removal including the dates and treating physicians for each:										YES	NO	
31. Are you an Epileptic or ever have had an Epileptic seizure? if yes, please list any and all medications you take for this condition:										YES	NO	
32. Do you have a Hernia? If yes, where?										YES	NO	
33. Have you had either a gain or loss of greater than ten (10) pounds in the past 12 months?										YES	NO	
34. Do you currently have any body piercing(s)?	YES	NO	If so, where?				Do you have a tattoo?		YES	NO		

F. NON-ATHLETIC SURGERY:

If you have ever had any non-athletic surgeries; list them below:

DATES	SURGICAL PROCEDURES	PHYSICIANS	COMPLICATIONS

G. NUTRITION, DRUGS, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS:

Check the appropriate space according to your use of the following products:

	NEVER	RARELY	OCCASIONALLY	FREQUENTLY
Stimulants (Benzedrine, Amphetamines, etc.)				
Chewing Tobacco, Snuff, or Smokeless Tobacco				
Cigarettes, Cigars, or Pipe				
Vitamins				
Sleeping Pills				
Diet Pills				
Alcoholic Beverages				
Anabolic Steroids (growth stimulants)				
Androstenedione				
Amino Acids				
Creatine phosphate				
Antihistamines				
Ephedrine				
Any other diet, nutritional or performance enhancing drug				

H. EATING DISORDERS:

1. Have you ever had a problem with food bingeing? If yes, when?	YES	NO
2. Has it ever been suggested or have you ever been diagnosed as being anorexic? If yes, when?	YES	NO
3. Have you ever been diagnosed as bulimic or having bulimia? If yes, when?	YES	NO
4. Do you sometimes or often induce vomiting after eating?	YES	NO
5. Have you or do you take laxatives to prevent being overweight?	YES	NO

ORTHOPAEDIC MEDICAL HISTORY:

I. FRACTURES:

1. Have you ever broken (fractured) a bone? If yes, please fill in the appropriate boxes below:						YES	NO
BODY PART	DATES		BODY PART	RIGHT	LEFT	DATES	
SKULL			COLLAR BONE				
NOSE			UPPER ARM				
FACE			FOREARM				
JAW			WRIST				
NECK			HAND				
SPINE			THIGH				
PELVIS			LOWER LEG				
RIBS			FOOT				
FINGERS	R_____	1____, 2____, 3____, 4____, 5____	L_____			1____, 2____, 3____, 4____, 5____	
TOES	R_____	1____, 2____, 3____, 4____, 5____	L_____			1____, 2____, 3____, 4____, 5____	
2. Did the fracture require surgery or create any residual defect? If yes, please describe the defect or type of surgery, date, physician, and location of the hospital.						YES	NO
3. Have you ever had a calcium deposit form in your thigh or anywhere else following a bad bruise? If yes, where is the calcium deposit located?						YES	NO
4. Have you ever had a bone spur develop and if so, where?						YES	NO

J. DISLOCATIONS:

1. Have you ever dislocated a joint? If yes, please fill out the appropriate boxes on the chart below:										YES	NO
	RIGHT	LEFT	# OF TIMES	DATES		RIGHT	LEFT	# OF TIMES	DATES		
SHOULDER					WRIST						
KNEE CAP					FINGERS						
ANKLE					TOES						
ELBOW											
2. Have you ever had surgery for a dislocation? If yes, describe surgery type, date, physician, and location of hospital below											

K. MUSCLE INJURIES:

1. Have you ever had a severe muscle pull or strain?			YES	NO
2. Has this injury reoccurred? If yes, list the muscle(s) involved and date(s):			YES	NO

L. NECK:

1. Have you ever sustained a serious neck or cervical injury?			YES	NO
2. Did you have numbness, burning, or sharp pain in your arms or legs?			YES	NO
3. Have you ever had an injury producing weakness or numbness of your arms or legs or both?			YES	NO
4. Were you ever transported by ambulance for a neck injury?	YES	NO	If yes, did you have neck or spinal X-Rays taken?	
5. Have you ever had neck surgery? If yes, describe surgery type, date, physician, and location of hospital below:			YES	NO
6. Have you ever had a burner or stinger (stretched or pinched nerve)?			YES	NO
7. Do you currently have any weakness due to a neck or spinal injury? If yes, give the location(s) of the weakness.			YES	NO

M. SPINE:

1. Have you ever injured your back? If yes, how many times? Please provide details regarding each injury including dates, treatment, rehabilitation, etc.			YES	NO
2. Were you ever diagnosed with a spinal defect of any type? If yes, provide details of defect?			YES	NO
3. Have you ever had back surgery? If yes, describe surgery type, date, physician, and location of hospital below.			YES	NO

N. SHOULDERS:

1. Have you ever had a significant shoulder joint injury?	L	R	YES	NO
2. Have you ever had an A-C sprain or separation?	L	R	YES	NO
3. Has your shoulder ever felt like it was unstable or slipping?	L	R	YES	NO
4. Have you ever had a problem with your shoulder repeatedly coming out of place?	L	R	YES	NO
5. Do you have any problems with your shoulder when trying to throw?	L	R	YES	NO
6. Do you have any problems with your shoulder with overhead activities?	L	R	YES	NO
7. Have you ever had shoulder surgery? If yes, describe surgery type, date, and physician below.	L	R	YES	NO

O. ELBOW, WRIST, HAND, FINGER:

1. Have you ever had an elbow injury or problem?	L	R	YES	NO
2. Have you ever had a wrist injury or problem?	L	R	YES	NO
3. Have you ever had a problem with hand or finger injury?	L	R	YES	NO
4. Do you have a finger deformity as a result of this injury? If so, which finger?	L	R	YES	NO
5. Have you ever had elbow, wrist, or hand/finger surgery? If yes, describe surgery type, date and physician below.			YES	NO

P. KNEES:

1. Have you ever had a significant knee injury? If yes, please describe the injury(s) you have sustained?	L	R	YES	NO
If you have had a significant knee injury or knee surgery, answer the following questions:				
A. Were you placed on a rehabilitation program?			YES	NO
B. Do you wear any type of preventative/protective brace when you practice or play?			YES	NO
2. Does your knee ever swell or collect fluid?	L	R	YES	NO
3. Did you have surgery for your knee injury(s)?	L	R	YES	NO
If yes, please describe the surgery type, date and physician				
4. Have you had surgery on either knee more than once?	L	R	YES	NO
5. Have you ever suffered from patellar tendinitis or jumper's knee?	L	R	YES	NO
6. Have you ever been diagnosed with Osgood-Schlatter's disease?	L	R	YES	NO

Q. ANKLES:

1. Have you ever sustained a severe ankle sprain?	L	R	YES	NO
2. Have you ever sustained a "high ankle sprain" or syndesmosis sprain?	L	R	YES	NO
3. Have you ever had surgery on your ankle(s)? If yes, describe the surgery type, date, and physician	L	R	YES	NO

R. FEET AND TOES:

1. Have you ever had a problem with bunions?	L	R	YES	NO
2. Have you ever had a problem with turf toe or sprained great toe?	L	R	YES	NO
3. Have you ever had a problem with ingrown toenails?	L	R	YES	NO

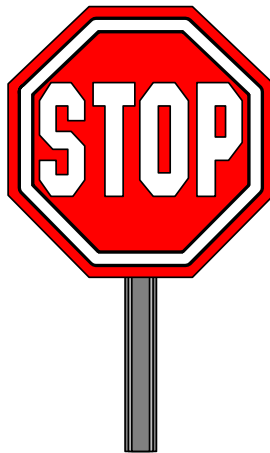
S. OTHER:

If you have any additional conditions, problems, or comments that have not been addressed thoroughly in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our best medical care.

All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

DATE _____ PRINTED NAME OF ATHLETE _____
(First) (Middle) (Last)

DATE _____ SIGNATURE OF ATHLETE _____



Stop here!

Please do not complete anymore. The remainder of this form is for family physician complete.

