

BENEDICTINE SPORTS MEDICINE ATHLETIC PHYSICAL EXAMINATION

1. Name _____ (M or F) _____ Age _____ Date _____
 2. SS # _____
 Sport(s) _____

MEDICAL HISTORY SURVEY

3. Do you have now or have you had in the past, problems with:	YES	NO	4. If you answered yes to any of #3, give details below- identify by letter.
a – Headaches – needing treatment			5. Have you ever been knocked unconscious? Yes ___ No ___ If yes, explain: _____
b – Heart			
c – Breathing, e.g. asthma			6. Have you ever had a cervical spine injury? Yes ___ No ___ If yes, explain: _____
d – Abdominal pain			
e – Dizzy spells			7. Do you have any permanent handicap or disability? Yes ___ No ___ If yes, explain: _____
f – Black outs			
g – Eyes (except glasses)			8. Are you under a physician's care at the present time? Yes ___ No ___ If yes, explain: _____
h – Hearing or ears			
i – Arthritis			9. Are you taking any medications at the present time? Yes ___ No ___ Give details: _____
j – Joint pain or swelling			
k – Knees-injury, giving out, swelling			10. Year of last Tetanus. _____
l – Spine – back or neck			
m – Broken bones			11. Women – Do you have a monthly menstrual period? Yes ___ No ___ Date of last period. _____ If no, explain: _____
n – Kidneys			
o – Bladder			12. Do you have an intense fear of gaining weight? Yes ___ No ___
p – Diabetes			
q – High blood pressure			
r – Cancer			
s – Operations or surgery			
t – Varicose veins			
u – Skin disorders			
v – Other major injuries			
w – Drug allergies			
x – Eating disorder			
y – Allergies			

TO BE COMPLETED BY EXAMING PHYSICIAN ONLY

13. Eyes: Rt. Eye _____ Lt. Eye _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Examination</th> <th style="width: 35%;">Normal</th> <th style="width: 35%;">Abnormal</th> </tr> </thead> <tbody> <tr><td>15. Head</td><td></td><td></td></tr> <tr><td>16. Eyes</td><td></td><td></td></tr> <tr><td>17. Nose & throat</td><td></td><td></td></tr> <tr><td>18. Ears</td><td></td><td></td></tr> <tr><td>19. Neck</td><td></td><td></td></tr> <tr><td>20. Lung</td><td></td><td></td></tr> <tr><td>21. Heart</td><td></td><td></td></tr> <tr><td>22. Abdomen</td><td></td><td></td></tr> <tr><td>23. Hernia/Testes</td><td></td><td></td></tr> <tr><td>24. Upper Extremity</td><td></td><td></td></tr> <tr><td>25. Extremity</td><td></td><td></td></tr> <tr><td>26. Shoulders</td><td></td><td></td></tr> <tr><td>27. Knees</td><td></td><td></td></tr> <tr><td>28. Other (Spine)</td><td></td><td></td></tr> <tr><td>29. Nervous</td><td></td><td></td></tr> <tr><td>30. Knee Laxity</td><td></td><td></td></tr> </tbody> </table>	Examination	Normal	Abnormal	15. Head			16. Eyes			17. Nose & throat			18. Ears			19. Neck			20. Lung			21. Heart			22. Abdomen			23. Hernia/Testes			24. Upper Extremity			25. Extremity			26. Shoulders			27. Knees			28. Other (Spine)			29. Nervous			30. Knee Laxity			14. General Information: Ht. _____ Wt. _____ BP _____ Pulse _____ <h4 style="text-align: center;">PHYSICIAN'S STATEMENT</h4> 32. Approved for sports Yes ___ No ___ 33. Approved pending further study Explain: _____ 34. Approved with limitations Explain: _____ 35. Disapproved comments: _____ 36. Date _____ Physician's Signature _____
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Benedictine College Athletic Medical History

THIS FORM TO BE COMPLETED BY STUDENT ATHLETE. PLEASE PRINT ALL INFORMATION.

Name: _____ Date of Birth: _____
Sport(s): _____ Year (s) of Participation (circle): 1 2 3 4 5
Emergency Contact: _____ Is this your first year of athletic participation
at Benedictine College? YES or NO
Daytime Phone: _____ Nighttime Phone: _____
Family Physician: _____ Office Phone: _____

The following conditions REQUIRE a letter from your physician clearing you from the injury or disorder before you are allowed to participate:

- A) Heart murmurs and abnormalities
- B) Bone and joint surgeries performed within one year of participation
- C) Any medical illness or disease which limits physical participation

1. Have any members of your family, under the age of 50, had a "heart attack" or "heart problems"? YES or NO
2. Do you have a heart murmur, extra heart beats, or a heart abnormality? YES or NO
3. Do you have high or low blood pressure, or are you taking medication for high or low blood pressure? YES or NO
4. Are you currently taking any medication on a daily basis? YES or NO
If YES, please list the medications and the conditions you are taking it for: YES or NO

5. Are you allergic to anything? (i.e. Penicillin, Sulfa, Aspirin, Codeine, Bee Stings, etc.) YES or NO
If YES, list everything you are allergic to:

6. Have you ever been "knocked out" or suffered a concussion? YES or NO
If YES, how many have you had? _____
Please list the dates of all head injuries: _____

7. Do you have asthma? YES or NO
If YES, list the medication(s) that you take:

8. Do you have a loss or impaired function of any paired organ? (Eyes, ears, lungs, kidneys, testicles, or ovaries) YES or NO
If YES, explain: _____

9. Have you ever had any of the following? Please circle the appropriate condition. DATE
- | | | |
|--|-----------|-------|
| Tuberculosis, hepatitis, or jaundice? | YES or NO | _____ |
| Anemia, leukemia or bleeding disorders? | YES or NO | _____ |
| Diabetes or epilepsy? | YES or NO | _____ |
| Dizzy spells, fainting or convulsions? | YES or NO | _____ |
| Ulcers, colitis, or other stomach problems? | YES or NO | _____ |
| Mumps, measles, rubella, or rheumatic fever? | YES or NO | _____ |
| Hernia, kidney or bladder problems? | YES or NO | _____ |
| Depression, mental illness, drug or alcohol addiction? | YES or NO | _____ |
| Arthritis or low back pain? | YES or NO | _____ |

10. Do you wear glasses? YES or NO
Do you wear contact lenses? YES or NO

11. Have you had any illness, condition or injury that:
- | | |
|---|-----------|
| Required you to go to an emergency room or stay overnight in a hospital? | YES or NO |
| Required a splint, cast or operation, or were advised to have an operation? | YES or NO |
| Lasted longer than one week? | YES or NO |
| Caused you to miss a game or practice? | YES or NO |
- If YES, please explain: _____
-

certify the above information is true and correct to the best of my knowledge. I have attached letters from my physician for the conditions listed above. All medical information is confidential.

Signature of Student-Athlete or Parent (if under 18)