MEDICAL HISTORY: Answer questions by circling yes (Y) or no (N). Please explain "yes" answers in the space provided. This portion of the form must be filled out by a parent or guardian. **A complete form** (history and physical exam) **is required for incoming freshmen, transfer students, as well as any student trying out for, practicing or participating in any athletic event**.

STUDENT NAME: _____

1. Have you had a medical illness or injury since your last check-up or physical? Y N
2. Have you been hospitalized overnight in the past year? Y N
3. Have you had surgery in the past year? Y N **If yes, explain** _____
4. Are you currently taking any prescription or non-prescription (OTC) medication or pills, or using an inhaler? Y N **If yes, list** _____
5. Do you have any allergies (for example, pollen, medicine, food or stinging insects? Y N **If yes, explain** _____
6. Have you ever passed out during or after exercise? Y N
7. Have you ever been dizzy during or after exercise? Y N
8. Have you ever had chest pain during or after exercise? Y N
9. Do you get tired more quickly than your friends do during exercise? Y N
10. Have you ever had a racing heart or skipped heartbeats? Y N
11. Have you ever had high blood pressure or high cholesterol? Y N
12. Have you ever been told you have a heart murmur? Y N
13. Has any family member been diagnosed with an enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome or abnormal heart rhythm? Y N
14. Has any family member or relative died of heart problems or of a sudden unexpected death before age 50? Y N **If yes, explain** _____
15. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last year? Y N
16. Has a physician ever denied or restricted your participation in sports for any heart problems? Y N **If yes, explain** _____
17. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)? Y N
18. Have you ever had a head injury or a concussion? Y N
19. Have you ever been knocked out, become unconscious or lost your memory? Y N **If yes, how many times?** _____ **When was the last concussion?** _____
20. Have you ever had a seizure? Y N Diagnosed with Epilepsy? Y N
21. Do you have frequent or severe headaches? Y N
22. Have you ever had numbness or tingling in your arms, hands, legs or feet? Y N
23. Have you ever had a stinger, burner or pinched nerve? Y N
24. Have you ever become ill from exercising in the heat? Y N
25. Have you ever gotten unexpected shortness of breath with exercise? Y N
26. Do you cough, wheeze or have trouble breathing during or after activity? Y N
27. Do you have asthma? Y N **If yes, are you under the care of a physician for asthma? Y N What medications do you take for asthma?** _____
28. Have you had any problems with your eyes or vision? Y N _____
29. Are you missing any paired organs? Y N
30. Do you use any special protective or corrective equipment or devises that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, and retainer on your teeth or a hearing aid)? Y N **If yes, explain** _____
31. Have you ever had a sprain, strain or swelling after an injury? Y N
32. Have you ever broken or fractured any bones or dislocated any joints? Y N **If yes, explain** _____
33. Have you ever had any other problems with pain or swelling in muscles, tendons, bones or joints? Y N **If yes, explain** _____
34. Are you satisfied with your current body weight? Y N Do you want to weigh MORE or LESS (circle one)? **MORE LESS**
35. Do you weigh regularly to meet weight requirements for your sport? Y N
36. Do you feel stressed? Y N Have you been treated for an emotional or nervous condition? Y N If yes, explain _____
37. Did you ever receive psychiatric treatment? Y N If yes, explain _____
38. Do you have ADD/ADHD Y N Please select one: **ADD ADHD**
39. Have you ever been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease? Y N
40. Are you under a doctor's care for #34, #35, #36, #37 or #38? Y N

Student Signature _____ Parent/Guardian Signature _____ Date _____

NOTE: Complete immunization records for **incoming freshmen and transfer students** are **REQUIRED**.

ST. THOMAS HIGH SCHOOL
BASILIAN FATHERS·1900

Please Print Legibly

Student's Name _____ Nick Name (if any) _____ Date of Birth _____

Graduation year: _____ what sport(s) are you playing, in seasonal order: 1. _____ 2. _____ 3. _____

Physical Examination/Pre-participation Physical Evaluation:

Height _____ Weight _____ Pulse _____ BP _____/_____/_____/_____/_____/_____

BMI _____ ANTEES _____ (Degree)

Vision: R 20 / _____ L 20 / _____ Corrected: Y N Contact Lenses _____ Glasses _____ Pupils: Equal _____ Unequal _____

Hearing: R _____ L _____ Pass Fail Refer

Spinal Screening: Type of Test _____ Results _____ Referral _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart supine			
Heart-Auscultation of the heart standing			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*** Station based examination only**

Comments Regarding Abnormal Findings: _____

PARTICIPATION RECOMMENDATIONS -- CLEARED: YES NO

Cleared after completing evaluation and/or rehabilitation for: _____

List any activity this student should be excluded from: _____

Not cleared for: _____ **Reason:** _____

Recommendations: _____

Medication taken routinely: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. ***Chiropractic examinations will not be accepted.***

Name of Physician (print/type): _____ **Date of Exam:** _____

Physician's Phone Number(s): _____

Physician's Address: _____

Physician's Signature: _____

COMPLETE IMMUNIZATION RECORD REQUIRED PLEASE ATTACH