

HISTORY FORM

Return to: MSOE Sports Medicine, 1025 N Broadway, Milwaukee WI, 53202. Fax: 414.277.2495
Kern Center 156A

(To be completed by patient *prior* to seeing physician.)

Name _____ Cell Phone # _____
Last Name First Name Middle

Sex _____ DOB ____/____/____ Age _____ Year in School: FR SOPH JR SR Home Ph # _____

Permanent Home Address: _____
Street City State Zip

Emergency Contact: _____ Ph # _____
Name Relationship

Medicines and Allergies: Please list all prescription and over-the-counter medications and supplements (herbal and nutritional) you are currently taking.

Do you have any allergies? YES NO If yes, please identify: Medications _____
 Insects _____ Food _____ Environmental _____

Explain "Yes" answers below in space provided in bottom of form – Thank You!

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any current medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever had an overnight stay in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race, skip beat, or irregularly beat during exercise?		
8. Has a doctor ever told you that you have a heart problem? If so, check those that apply: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Infection <input type="checkbox"/> Kawasaki Disease Other: _____		
9. Has a doctor ever ordered any special test for your heart?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever experienced an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than others during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected/unexplained death before age 50 (drowning, unexplained car accident, sudden infant death)?		
14. Does anyone in your family have Marfan syndrome, hypertrophic cardiomyopathy, long or short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia)?		
15. Does anyone in your family have a heart problem, Pacemaker or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever had a neck injury that required x-rays?		
22. Do you regularly use a brace, orthotics, or other device?		
23. Do you have a current bone, muscle, or joint injury?		
24. Do any of your joints swell, become warm, painful, or red?		
25. Do you have a history of juvenile arthritis or tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or take asthma medication?		
28. Does anyone in your family have asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis in the last month?		
32. Do you have any rashes, pressure sores, or skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of a seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in heat?		
41. Do you get frequent muscle cramps while exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended you gain or lose weight?		
49. Are you on a special diet or avoid certain types of food?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns you would like to discuss with the physician?		
FEMALES ONLY	Yes	No
52. Do you have a monthly menstrual period?		
53. Do you have excessive pain or bleeding with your period?		
54. How many periods have you had in the last 6 months?		

Explain "Yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are accurate and complete.

X _____ Date _____
Signature Required (if minor, signature of Parent/Guardian)

PHYSICAL EXAMINATION FORM Return to MSOE Sports Medicine, 1025 N Broadway, Milwaukee WI, 53202. Fax: 414.277.2495
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Name _____ Date of Birth _____

Examination Prompts:

- Stress level
- Sad, hopeless, depressed, or anxious signs/sx's
- Feeling of safety at home
- Risk behaviors – helmet, seat belt, protection (if sexually active)
- Tobacco, alcohol, or illegal drug use
- Supplement use

Consider reviewing questions 5-12 on cardiovascular health from History Form.

EXAMINATION		
Height: _____	Weight: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP: _____ / _____	Heart Rate/Pulse: _____	Vision Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No R 20 / _____ L 20 / _____
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance ■ Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat ■ Pupils equal ■ Hearing		
Lymph Nodes		
Heart ■ Murmurs, (auscultation standing, supine, +/- Valsalva) ■ Location of point of maximal impulse (PMI)		
Pulses		
Lungs		
Abdomen		
Genitourinary (males)		
Skin ■ HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional ■ Duck-walk, Tip-toe walk, Single leg hop		

Cleared for all sports and/or nursing clinicals without restriction

Cleared for all sports and/or nursing clinicals with recommendations for further evaluation, treatment, or modification: _____

Not Cleared

- Pending further evaluation
 - For any sports
 - For certain sports: _____
- Reason: _____

Recommendations: _____

I have examined the above-named student-athlete and completed the preparticipation physical evaluation. The student-athlete does not present apparent clinical contraindications to practice and participate in the intercollegiate sport(s) as outlined above. If conditions arise after the student-athlete has been cleared for participation, the physician or health care provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student-athlete (and parents/guardian if so applies).

Name of MD/APN/PA (print/type) _____ Date _____

Address _____ Phone _____

Signature _____