Bacone College

MEDICAL HISTORY & PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

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

Student No: _____/ _____/ _____ Classification: Fr. So. Jr. Sr. Red Shirt Sr.
(Different than Social Security No.)

e-Mail Address(es): _____

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

I. Person to notify in case of an Emergency: _____ Relationship: _____

Address: _____
(City) (State) (Zip)

Home Phone: (_____) _____ Business Phone: (_____) _____

Cell Phone (_____) _____ e-Mail: _____

II. Father's Name: _____

Address: _____

_____
(City) (State) (Zip)

Employer: _____ e-mail: _____

Home Phone: (_____) _____

Business Phone: (_____) _____

Cell Phone (_____) _____

III. Mother's Name: _____

Address: _____

_____
(City) (State) (Zip)

Employer: _____ e-mail: _____

Home Phone: (_____) _____

Business Phone: (_____) _____

Cell Phone (_____) _____

IV. Marital Status (if applicable) S M W D Separated Spouse's Name: _____

Address: _____ e-Mail: _____
(City) (State) (Zip)

Home Phone: (_____) _____ Business Phone: (_____) _____ Cell Phone: (_____) _____

V. Athlete Insured by: _____ Policy #: _____ _____

Claims Address: _____
(City) (State) (Zip)

Preauthorization for services required? _____ Prescription Insurance Co: _____ Card #: _____

Insurance Deductable : _____

Does Primary Insurance Cover Athletic Injury? _____

Attach a copy of your insurance card, front and back.

I hereby certify that the answers provided are true and correct to the best of my knowledge. A photocopy of this authorization shall be considered as effective and valid.

Date: _____ Signature: _____

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:						**Blood type:** A+ A- B+ B- AB+ AB- O+ O-		

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				Albumin In Urine				Psychiatric Problems			
Scarlet Fever				Painful Urination				Fear of High Places			
Typhoid Fever				Frequent Urination				Excessive Worry			
Chicken Pox				Rectal Bleeding				Depression			
Small Pox				Rectal Itching				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			
Urinary Tract Infection				Herpes Virus				Gout			

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				Scanty Flow				Absence of Menstruation			
Number of Births				Excessive Flow				Painful Menstruation			
Abnormal Pap Smears				Vaginal Discharge				Menstrual Cramps			
Last Pap Smear				Length of Cycle				Irregular Periods			
Last Period				Period Duration				Lumps in Breast			
Endometriosis				Age Periods Began				Genital Itching			

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 (EAI)? 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:

	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					ELBOW				
A-C JOINT					WRIST				
KNEE CAP					HIP				
KNEE					FINGERS				
NECK					TOES				
ANKLE									

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?	**YES**	**NO**
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, physician, and the location of hospital 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, physician, and the location of hospital 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, physician, and the location of the hospital where surgery was performed				
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, physician, and location of the hospital below.	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.

_____

_____

_____

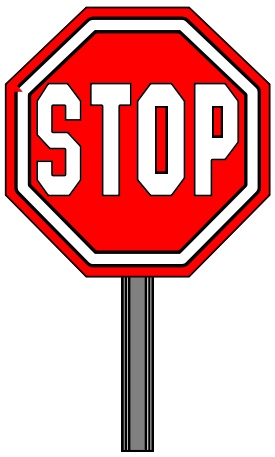
_____

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 the sports medicine staff to complete.

HEIGHT:_____ NECK GIRTH:_____CHEST_____ BICEPS: R)_____ BICEPS L) _____

WEIGHT: _____ NECK LENGTH:_____ABDOMEN:_____ CALF: R)_____ CALF L) _____

BODY COMPOSITION: _____% _____ THIGH: R) _____ _____ L) _____ _____

Formula (Above Medial Knee Joint) 4" 7" 4" 7"

NECK: ROM: Normal, Restricted _____

History of Injury: _____

Physician Comments: _____

SHOULDER: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

Physician Comments: _____

Deltoid Strength R) Good ( ) Weak ( )
L) Good ( ) Weak ( )

Supraspinatus R) Good ( ) Weak ( )
L) Good ( ) Weak ( )

Internal Rotation R) Good ( ) Weak ( )
L) Good ( ) Weak ( )

External Rotation R) Good ( ) Weak ( )
L) Good ( ) Weak ( )

ELBOW: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

Physician Comments: _____

WRIST: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

Physician Comments: _____

HANDS & FINGERS: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

Deformities: _____

Physician Comments: _____

SPINE: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

Posture: ( ) Normal ( ) Scoliosis ( ) Kyphosis ( ) Lordosis

Physician Comments: _____

HIP: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury _____

Psoas Muscle: R): Tight, Flexible
L): Tight, Flexible

Rectus Femoris: R): Tight, Flexible
L): Tight, Flexible

Hamstring: R): Tight, Flexible _____(degrees)
L): Tight, Flexible _____(degrees)

Hip Flexor Strength: R): Strong, Weak
L): Strong, Weak

Physicians Comments: _____

KNEE: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

	Right	Left	Comments		Right	Left	Comments
Bowleg (Genu Varum)				Plica			
Knock Knee (Genu Valgum)				Q Angle			
Back Knee (Genu Recurvatum)				Abduction Stress (30°)			
Hyperextension Lift				Abduction Stress (0°)			
Patella Lateral				Adduction Stress (30°)			
Patella High (Alta)				Adduction Stress (0°)			
Patella Low (Baja)				Lachman Test			
Patella Hypermobile				McMurray's Test			
Anterior Drawer (ER)				Jerk/Pivot Shift			
(N)				VMO Dysplasia			
(IR)				Posterior Drawer			

Physician Comments: _____

ANKLE: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

	Right	Left	Comments		Right	Left	Comments
Dorsiflexion (with knee fully extended)				Anterior Drawer Test			
Jump Test				Inversion Stress Test			
				Eversion Stress Test			

Physician Comments: _____

FEET & TOES: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

ARCH: R): NORMAL, HIGH, LOW **REARFOOT:** R): NEUTRAL, PRONATED, SUPINATED

L): NORMAL, HIGH, LOW L): NEUTRAL, PRONATED, SUPINATED

Physicians Comments: _____

VISUAL ACUITY: L)_____ R)_____ DOMINANCE: EYE_____ HAND_____

HEARING:		500	1000	2000	4000		500	1000	2000	4000
	Left					**Right**				

URINALYSIS:	Glucose	Bilirubin	Ketone	SG	Blood	Ph	Protein	Urobilinogen	Nitrate	Leukocytes

GENERAL MEDICAL:

BLOOD PRESSURE: _____ **PULSE:** _____

	NORMAL	**ABNORMAL**		**NORMAL**	**ABNORMAL**
HEAD			RESPIRATORY		
EYES			HEART		
EAR, NOSE, THROAT			ABDOMEN		
NECK			URINARY		
SKIN			OTHER		

Physicians Comments: _____

DENTAL:

OVERALL PHYSICAL EXAMINATION RESULTS:

RESULTS	CHECK ONE	COMMENTS
PASSED WITHOUT LIMITATIONS		
PASSED PENDING THE FOLLOWING:		
FAILED DUE TO THE FOLLOWING:		

At this date, I can find no physical abnormality that would deter this student from fully participating in all of the sports listed below, except the ones that are circled:	Badminton, Baseball, Basketball, Cheerleading, Cross Country, Football, Golf, Rodeo, Soccer, Softball, Swimming, Tennis, Track & Field, Volleyball, Weight Training, Wrestling

Physician's Signature:_____ Date: _____