

2011-2012 SPORTS QUALIFYING PHYSICAL HISTORY FORM
Minnesota State High School League

Student Name: _____ Birth Date: _____ Date of Exam: _____

Circle Question Number (1) of questions for which the answer is unknown.

History

Circle Y for Yes or N for No

GENERAL QUESTIONS

- 1. Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports?
2. Do you have an ongoing medical condition (like diabetes, asthma, anemia, infections)?
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?
4. Do you have allergies to medicines, pollens, foods, or stinging insects?
5. Have you ever spent the night in a hospital?
6. Have you ever had surgery?

HEART HEALTH QUESTIONS ABOUT YOU

- 7. Have you ever passed out or nearly passed out DURING exercise?
8. Have you ever passed out or nearly passed out AFTER exercise?
9. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
10. Does your heart race or skip beats (irregular beats) during exercise?
11. Has a doctor ever told you that you have? (circle): High blood pressure, A heart murmur, High cholesterol, A heart infection, Rheumatic fever, Kawasaki's Disease
12. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram, stress test)
13. Do you get lightheaded or feel more short of breath than expected during exercise?
14. Have you ever had an unexplained seizure?
15. Do you get more tired or short of breath more quickly than your friends during exercise?

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

- 16. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including unexplained drowning, unexplained car accident, or sudden infant death syndrome)?
17. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?
18. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
19. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

BONE AND JOINT QUESTIONS

- 20. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?
21. Have you had any broken or fractured bones or dislocated joints?
22. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
23. Have you ever had a stress fracture?
24. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)
25. Do you regularly use a brace, orthotics or other assistive device?
26. Do you have a bone, muscle, or joint injury that hinders you?
27. Do any of your joints become painful, swollen, feel warm, or look red?
28. Do you have any history of juvenile arthritis or connective tissue disease?

MEDICAL QUESTIONS

- 29. Has a doctor ever told you that you have asthma or allergies?
30. Do you cough, wheeze, experience chest tightness, or have difficulty breathing during or after exercise?
31. Is there anyone in your family who has asthma?
32. Have you ever used an inhaler or taken asthma medicine?
33. Do you develop a rash or hives when you exercise?
34. Were you born without or are you missing a kidney, an eye, a testicle (males), or any other organ?
35. Do you have groin pain or a painful bulge or hernia in the groin area?
36. Have you had infectious mononucleosis (mono) within the last month?
37. Do you have any rashes, pressure sores, or other skin problems?
38. Have you had a herpes or MRSA skin infection?
39. Have you ever had a head injury or concussion?
40. Have you ever had a hit or blow to the head that caused confusion prolonged headache, or memory problems?
41. Do you have a history of seizure disorder?
42. Do you have headaches with exercise?
43. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
44. Have you ever been unable to move your arms or legs after being hit or falling?
45. Have you ever become ill while exercising in the heat?
46. Do you get frequent muscle cramps when exercising?
47. Do you or someone in your family have sickle cell trait or disease?
48. Have you had any problems with your eyes or vision?
49. Have you had any eye injuries?
50. Do you wear glasses or contact lenses?
51. Do you wear protective eyewear, such as goggles or a face shield?
52. Do you worry about your weight?
53. Are you trying to or has anyone recommended that you gain or lose weight?
54. Are you on a special diet or do you avoid certain types of foods?
55. Have you ever had an eating disorder?
56. Do you have any concerns that you would like to discuss with a doctor?

FEMALES ONLY

- 57. Have you ever had a menstrual period?
58. How old were you when you had your first menstrual period?
59. How many menstrual periods have you had in the last year?

Notes: _____

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities.

Parent or Legal Guardian Signature _____ Student Athlete Signature _____ Date _____

2011-2012 SPORTS QUALIFYING PHYSICAL EXAMINATION FORM

Minnesota State High School League

Student Name: _____ Birth Date: _____ Age: _____ Gender: M / F

Follow-Up Questions About More Sensitive Issues:

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Question "Risk Behaviors" like guns, seatbelts, unprotected sex, domestic violence, drugs, and others.

Notes About Follow-Up Questions:

MEDICAL EXAM

Height _____ Weight _____ BMI (optional) _____ % Body fat (optional) _____ Arm Span _____
 Pulse _____ BP _____ / _____ (_____ / _____)
 Vision: R 20/ _____ L 20/ _____ Corrected: Y / N Contacts: Y / N Hearing: R _____ L _____ (Audiogram or confrontation)

Exam	Normal	Abnormal Notes	Initials*
Appearance	Y / N		
Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)	Y / N		
HEENT	Y / N		
Eyes	Y / N		
Fundoscopy	Y / N		
Pupils	Equal / Unequal		
Hearing	Y / N		
Cardiovascular	Y / N		
Murmurs (auscultation standing, supine, +/- Valsalva)	Y / N		
PMI location			
Pulses: (simultaneous femoral & radial)	Y / N		
Lungs	Y / N		
Abdomen	Y / N		
Genitourinary (Male)	Y / N		
Hernia	Y / N		
Tanner Staging (optional)	I II III IV V		
Skin (HSV, MRSA, Tinea corporis)	Y / N		
Musculoskeletal			
Neck	Y / N		
Back	Y / N		
Shoulder/Arm	Y / N		
Elbow/Forearm	Y / N		
Wrist/Hand/Fingers	Y / N		
Hip/Thigh	Y / N		
Knee	Y / N		
Leg/Ankle	Y / N		
Foot/Toes	Y / N		
Functional (Duck Walk/Single Leg Hop)	Y / N		

* Required Only if Multiple Examiners

Notes: _____

Assessment: Cleared for sports without restriction Restricted participation (see Clearance Form)

Plan: Immunizations: Up-to-Date Immunize if needed (Required by age 12: DTaP series plus Td with Pertussis (Tdap), 4 Hib, 2 MMR, 3 HBV, 4 IPV, 2 varicella)

Health Maintenance: Consider Flu Shot (Asthma, winter athletes) Discussed dental care and mouthguard use

Lifestyle, health, and safety counseling Discussed Lead and TB exposure - (Testing indicated / not indicated)

Attending Physician Signature: _____ Date: _____