UNIVERSITY OF THE DISTRICT OF COLUMBIA SPORTS MEDICINE

STUDENT-ATHLETE PHYSICAL EXAMINATION

(To be completed by a physician prior to participation every year)

Name: ____ **UID:**_______________________________

Sport(s):____

Sex	Age	Date of Birth	Race	Height	Weight	Weight 1 yr ago
Vision Screen **R** 20/ **L** 20/	Vision Corrected Y N	Color test	Blood Pressure /	Heart Rate	Allergies	

ORTHOPEDIC EXAMINATION (to be completed by physician):		
	NORMAL	**ABNORMAL FINDINGS (use back and/or additional sheets if needed)**
NECK		
BACK		
SHOULDERS / ARM		
ELBOW / FOREARM		
WRIST / HAND / FINGERS		
HIP/THIGH		
KNEE		
LEG/ANKLE		
FOOT/TOES		
FLEXIBILITY		
CLINICAL EXAMINATION (to be completed by physician):		
HEAD, FACE, NECK, & SCALP		
NOSE / SINUSES		
MOUTH / THROAT		
EARS		
EYES		
LUNGS / CHEST		
HEART / CARDIOVASCULAR/ EKG		
ABDOMEN / GI		
GENITOURINARY SYSTEM		
SKIN / LYMPATICS		
NEUROLOGICAL		

STUDENT-ATHLETE PHYSICAL EXAMINATION

Name: ____

STATUS: (Physician indicate a response below)

- Pass without restrictions
- Pass with restrictions: ____
- Further Evaluation Needed

Referred to____

For____

Examiner Signature	**Date**	**Examiner Print Name**

PHYSICIAN'S OFFICE STAMP REQUIRED

INITIAL HEALTH HISTORY QUESTIONNAIRE

(To be filled out by the Student-Athlete)

I. Cardiovascular Risk Factors:

·Have you ever had **chest pain, dizziness, fainting and/or shortness of breath** during or after exercise / practice? YES NO
If YES, describe diagnosis and date: ____

·Have you ever been told that you have a **heart murmur**? YES NO
If YES, describe diagnosis and date: ____

·Has any family member or relative **died or heart problems and/or of sudden death before age 50**? YES NO
If YES, describe diagnosis: ____

·Has a physician **ever denied or restricted your participation in sports** due to any heart / cardiovascular problems? YES NO
If YES, describe diagnosis and date: ____

·Have you ever had an electrocardiogram **(EKG)** and/or echocardiogram **(ECHO)** of your heart? YES NO
If YES, describe diagnosis/results and date: ____

·Do you or anyone in your family have a history of **high blood pressure**? YES NO
If YES, describe who in your family: ____

·Do you or anyone in your family have a history of **high blood cholesterol**? YES NO
If YES, describe who in your family: ____

II. Allergies:

·Have You Ever Been Diagnosed with **ANY** Allergies or had any unfavorable reactions to foods, insects and/or drugs? YES NO
If YES, describe allergy and date: ____

·Are You Presently Taking/Have You Previously Taken Any Allergy Medications? YES NO
If YES, list medication and date: ____

III. Asthma:

·Have You Ever Been Diagnosed With *Asthma and/or Exercised Induced Asthma*? YES NO
If YES, describe diagnosis and date: ____

·Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler? YES NO
If YES, list medication and date: ____

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition? YES NO
If YES, list dates held out of participation: ____

IV. Head Injuries / Concussion:

·Have You Ever Suffered a *Head Injury / Concussion* (no matter how minor)? YES NO
If YES, describe diagnosis and date: ____

·Have You Ever Been Evaluated By a Doctor for a Head Injury / Concussion? YES NO
If YES, describe diagnosis and date: ____

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____

·Have You Ever Been *Hospitalized, Knocked Out, and/or Suffered Memory Loss to A Head Injury / Concussion*? YES NO
If YES, describe diagnosis and date: ____

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion? YES NO
If YES, list dates held out of participation: ____

V. Eye:

·Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? YES NO
If YES, describe diagnosis and date: ____

· Do you routinely wear glasses and/or contact lenses? YES NO

VI. Ear / Nose / Throat:

·Have You Ever Suffered An Injury To Your *Ear(s), Nose, and/or Throat*? YES NO
If YES, describe diagnosis and date: ____________________

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____________________

·Have You Ever Been Hospitalized For An Ear, Nose, and/or Throat Injury? YES NO
If YES, describe diagnosis and dates hospitalized: ____________________

·Do you have ringing in your ears or trouble hearing? YES NO

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ear, Nose, and/or Throat Injury? YES NO
If YES, list dates held out of participation: ____________________

VII. Dental:

·Have You Ever Suffered An Injury To Your *Mouth, Jaw, and/or Teeth*? YES NO
If YES, describe diagnosis and date: ____________________

VIII. Cervical Spine / Neck:

·Have You Ever Suffered An Injury To Your *Cervical Spine and/or Neck*? YES NO
If YES, describe diagnosis and date: ____________________

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____________________

·Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury? YES NO
If YES, describe diagnosis and dates hospitalized: ____________________

·Have You Ever Had “Burners”, “Stingers”, or Brachial Plexus Injuries? YES NO
If YES, describe diagnosis and date: ____________________

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury? YES NO
If YES, list dates held out of participation: ____________________

IX. Shoulder / Arm / Elbow / Wrist / Hand:

·Have You Ever Suffered An Injury To Your *Shoulder / Arm / Elbow / Wrist / Hand*? YES NO
If YES, describe diagnosis and date: ____________________

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____________________

·Have You Ever Had Surgery of Any Kind on Your Shoulder / Arm / Elbow / Wrist / Hand? YES NO
If YES, describe diagnosis and date: ____________________

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Arm / Elbow / Wrist/ Hand Injury?
YES NO
If YES, list dates held out of participation: ____________________

X. Spine / Low Back / Sacroiliac Joint:

·Have You Ever Suffered An Injury To Your *Spine / Low Back / Sacroiliac Joint*? YES NO
If YES, describe diagnosis and date: ____________________

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____________________

·Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint? YES NO
If YES, describe diagnosis and date: ____________________

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury? YES NO
If YES, list dates held out of participation: ____________________

XI. Hip / Groin:

·Have You Ever Suffered an Injury to Your *Hip / Groin (including hernias and/or sports hernias)?* YES NO
If YES, describe diagnosis and date: ____

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____

·Have You Ever Had Surgery For A Hip / Groin Injury? YES NO
If YES, describe diagnosis and date: ____

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury? YES NO
If YES, list dates held out of participation: ____

XII. Thigh / Hamstring / Quadriceps:

·Have You Ever Suffered An Injury To Your *Thigh, Hamstring, and/or Quadriceps*? YES NO
If YES, describe diagnosis and date: ____

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____

·Have You Ever Had Surgery For A Thigh, Hamstring and/or Quadriceps Injury? YES NO
If YES, describe diagnosis and date: ____

·Have You Ever Been Advised Not To Participate Due To A Thigh, Hamstring, or Quadriceps Injury? YES NO
If YES, list dates held out of participation: ____

XIII. Knee / Patella:

·Have You Ever Suffered an Injury to Your *Knee and/or Patella (kneecap)*? YES NO
If YES, describe diagnosis and date: ____

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____

·Have You Ever Had Surgery For A Knee and/or Patella Injury? YES NO
If YES, describe diagnosis and date: ____

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury? YES NO
If YES, list dates held out of participation: ____

XIV. Ankle / Lower Leg / Foot:

·Have You Ever Suffered An Injury To Your *Ankle / Lower Leg or Foot*? YES NO
If YES, describe diagnosis and date: ____

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____

·Have You Ever Had Surgery For An Ankle / Lower Leg / Foot Injury? YES NO
If YES, describe diagnosis and date: ____

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury? YES NO
If YES, list dates held out of participation: ____

XV. Abdomen / Ribs / Thorax / Chest:

·Have You Ever Suffered An Injury To Your Abdomen / Rib / Thorax / Chest? YES NO
If YES, describe diagnosis and date: ____

·Were Any Diagnostic Tests Performed? YES NO
If YES, please list and specify for which injury: ____

·Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? YES NO
If YES, describe diagnosis and date: ____

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? YES NO

If YES, list dates held out of participation: ____

XVI. Medical Testing:

·Have You Ever Been diagnosed With a Communicable Disease? YES NO
(e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis, etc)
If YES, describe diagnosis and date: ____

XVII. Dermatological (Skin):

·Do you have any skin problems that we should be aware of? YES NO
(e.g. ringworm, herpes, skin infection, itching, rashes, acne, warts, eczema, fungus, etc.)
If YES, describe diagnosis and date: ____

·Have you ever been diagnosed with a staph infection and/or MRSA infection on any part of your body? YES NO
If YES, describe diagnosis and date: ____
·Have you ever had a rash or hives develop during and/or after exercise? YES NO
If YES, describe diagnosis and date: ____

·Have you ever been under the care of a dermatologist for any condition? YES NO
If YES, describe diagnosis and date: ____

XVIII. Prescription Medications:

Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken** In The PAST 6 Months, & For What Purpose:

MEDICATION	**PURPOSE**	**DOSAGE**	**DATE(S)**

XIX. Supplements / Ergogenic Aids:

Please List **ALL** Supplements / Cryogenic Aids That You Are **CURRENTLY** Taking or **Have Taken** In the PAST Two (2) Years, & For What Purpose:

SUPPLEMENT	**PURPOSE**	**DOSAGE**	**DATE(S)**

XX. Heat Related Problems:

·Have You Ever Suffered From A Heat Related Injury? YES NO
If YES, check all that apply and date:
□Heat Cramps Date(s):____
□Heat Syncope (Fainting) Date(s):____
□Heat Exhaustion Date(s):____
□Heat Stroke Date(s):____

·Have You Ever Been Hospitalized For a Heat-Related Problem? YES NO
If YES, describe diagnosis and dates hospitalized: ____

·Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury? YES NO
If YES, list dates held out of participation: ____

XXI. Diabetic History:

·Have You Ever Been Diagnosed With Diabetes? YES NO

If YES, describe diagnosis and date: ____

·Are You Presently Taking or Have You Taken Any Diabetic Medications? YES NO

If YES, please describe below:

Medication	Form	Dosage	Frequency

Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:

____

XXII. Females Only:

·At what age did you have your first menstrual period? ____

·Have you had menstrual periods within the past 12 months? YES NO

If YES, how many? ____

·Do you take prescribed birth control? YES NO

If YES, please list the brand: ____

·Do you take any medications during your menstrual periods? YES NO

If YES, please list what medication and dosage: ____

XXIII. Please Answer: ***Please use space provided to describe in detail. You may use the back of this sheet.***

·Have you ever had any injury or illness other than those already noted? YES NO

If YES, please describe: ____

·Do you have any ongoing or chronic illnesses not already noted? YES NO

If YES, please describe: ____

·Have you ever been hospitalized overnight for a reason not already noted? YES NO

If YES, please list dates of hospitalization and why: ____

·Are you currently under a physician's care for any medical conditions? YES NO

If YES, please describe: ____

·Have you ever been under the care of a psychiatrist and/or psychologist? YES NO

If YES, describe diagnosis and date: ____

·Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years? (**Circle all that apply and circle YES**.) YES NO

If YES, please describe: ____

·Do you cough, wheeze, have chest tightness, have shortness of breath, or have trouble breathing during or after exercise / practice, at night, or after exposure to allergens / pollutants? YES NO

If YES, please describe: ____

·Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months? YES NO

If YES, describe diagnosis and date: ____

·Have you ever had seizures, convulsions, and/or epilepsy? YES NO

If YES, describe diagnosis and date: ____

·Have you ever had an abnormal chest x-ray and/or pneumonia? YES NO

If YES, describe diagnosis and date: ____

·Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)? YES NO

If YES, describe equipment, why you need it, and date: ____

·Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form? YES NO
If YES, please describe and at what frequency: ____

·Do you use alcohol? YES NO
If YES, please describe and at what frequency: ____

·Do you have any questions regarding drugs, tobacco, or alcohol? YES NO
If YES, please contact your Athletic Trainer immediately.

·Do you feel stressed out? YES NO
If YES, do you feel as though you get the necessary support to deal with your stress? YES NO
If no, please contact your Athletic Trainer immediately.

·Have you had a weight change (loss or gain) of greater than 10 pounds in the past year? YES NO
If YES, please contact your Athletic Trainer immediately.

·Are you on any specific diet (vegetarian, pescatarian, vegan, etc)? YES NO
If YES, please describe: ____

·Do you currently have, or used to have, a history of anorexia, bulimia, and/or any other eating disorders? YES NO
If YES, have you sought treatment? YES NO
If YES, please describe diagnosis and date: ____
If no, please contact your Athletic Trainer immediately.

If you have any other medical conditions or injuries not previously indicated, please explain here:___________________________
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I verify that all the information is accurate and complete. I understand that failure to disclose previous medical conditions may result in a medical disqualification. I understand that University of the District of Columbia is not responsible for expenses related to any previously existing conditions.

____ ____________________
Student-Athlete Signature (Print Name) Date

____ ____________________
Parent/Guardian Signature *(if under 18 years of age)* (Print name) Date

UNIVERSITY OF THE DISTRICT OF COLUMBIA SPORTS MEDICINE

STUDENT-ATHLETE MEDICAL UPDATE

Name: **UID:** **Sport:**

IN THE PAST 6 MONTHS, HAVE YOU…

Had a serious injury / been hospitalized?	YES NO	Had an unfavorable/allergic reaction to a drug, antibiotic and/or medicine?	YES NO
Had a sprain / strain / fracture?	YES NO	Had a dental injury?	YES NO
Been unconscious for any other reason other than anesthesia?	YES NO	Do you have any allergies?	YES NO
Had a neck injury?	YES NO	Do you take any medications for pain or a medical condition on a regular basis?	YES NO
Had a back injury or suffered from back pain?	YES NO	Had frequent headaches?	YES NO
Had any burners, stingers, numbness in neck, shoulder, and/or hand?	YES NO	Experienced coughing, wheezing, shortness of breath, or breathing difficulties during or after exercise?	YES NO
Had a shoulder, elbow, hand, or wrist injury?	YES NO	Do you have any ongoing or chronic illnesses?	YES NO
Had a hip and/or knee injury?	YES NO	Had an operation?	YES NO
Had a lower leg, ankle, and/or foot injury?	YES NO	Do you wear contact lenses, glasses, and/or safety glasses?	YES NO
Missed a practice and/or game due to an injury and/or illness?	YES NO	Have you had a history of anorexia, bulimia and/or any other eating disorder?	YES NO
Are you currently undergoing physical therapy or rehabilitation for an injury?	YES NO	Do you require any special equipment to participate in athletics?	YES NO
Had a staph infection / MRSA infection?	YES NO	Have you been told by a physician to restrict your activity or not to participate in sport?	YES NO
While exercising, has your heart ever "skipped" a beat, have you suffered from "racing heart", severe chest pain, lightheadedness, or fainted?	YES NO	Had a heat related illness (heat cramps, heat exhaustion, and/or heat stroke) and/or received special attention (IV fluids, etc) for a heat related problem?	YES NO
Been diagnosed with any **NEW** injuries and/or medical problems?	YES NO	Do you take vitamins, amino acids, creatine, and/or any other dietary supplement?	YES NO
Been evaluated by an orthopedic?	YES NO	Been recently diagnosed with infectious mononucleosis ("mono"), Hep B or C, HIV/AIDS and/or any other severe infectious disease / viral infection?	YES NO
Have you ever felt dizzy, passed out, or "blacked out" during or after exercise?	YES NO	Been denied clearance by a medical professional to participate in athletics?	YES NO

Please explain all YES answers here:____

____

I verify that all the information is accurate and complete. I understand that failure to disclose previous medical conditions may result in a medical disqualification. I understand that University of the District of Columbia is not responsible for expenses related to any previously existing conditions.

_______________________________________ _______________

Student-Athlete Name Date

_______________________________________ _______________

Parent/Guardian Name *(if under 18 years of age)* Date