



Student-Athlete Information and Medical History

(All information will be kept confidential)

Student-Athlete Information:

Name: _____ Today's Date: _____

Year in School (circle): Fresh. Soph. Jun. Sen. Grad. Sex (circle): Male Female

Sport(s): _____ Birthdate: _____ Age: _____

Local Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Cell: _____

Marital Status: Single Married Divorced Widowed Separated

Spouse Name: _____ Cell: _____

Guardian / Emergency Contact Information:

Name:
Relationship:
Address:
City:
State / Zip Code:
E-mail:
Cell:

Name:
Relationship:
Address:
City:
State / Zip Code:
E-mail:
Cell:

Family Physician Contact Information:

Name:	Address:
E-mail:	City:
Phone:	State / Zip Code:

Allergies (medications, food, environmental, insects, etc.):

Allergy:	Reaction:

Medications / Shots (taken on a regular basis):

Medication:	Dose:	Frequency (daily, 2x daily, etc.):



Personal Medical History:

Date of last medical examination/physical by a physician/doctor: _____

Do you, or have you, had any of the following conditions? If so, please explain below.

Condition:	Y	N
Sinus Infection		
Asthma / Exercise Induced Asthma		
Fatigue / Shortness of Breath		
Chronic Colds / Cough		
Chicken Pox		
Pneumonia		
Hepatitis		
Diabetes		
Jaundice		
Marfan Syndrome		
Tuberculosis ("TB")		
Mononucleosis ("Mono")		
Sickle Cell Disease		
Anemia / Low Iron		
Bronchitis		
Recurrent Strep Throat		
Recurrent Tonsillitis		
Rheumatic Fever		
MRSA / Staph Infection		
Hives		
Eczema		
Psoriasis		
Ulcers		
Hemorrhoids		
Recurrent Diarrhea		
Urinary Tract Infection		
Recent Rapid Loss / Increase Weight		
Eating Disorder		
Recently Pregnant (Women only)		

Condition:	Y	N
Heat Related Illness (Hyperthermia)		
High Blood Pressure (Hypertension)		
High Cholesterol		
Heart Murmur or Palpitations		
Chest Pains or Discomfort		
Family History of Sudden Death		
Sudden Cardiac Arrest		
Heart Attack		
Stroke		
Dizziness / Fainting		
Frequent Headaches / Migraines		
Head Injury / Concussion		
Epilepsy / Seizures		
Hearing Loss / Impairment		
Glasses During Practice/Competition		
Contacts During Practice/Competition		
Wear Dental Appliance		
Shoe Orthotics		
Nose Bleeds		
Blood Clots		
Joint Disease / Arthritis		
Abdominal Pain		
Hernia / Hernia Surgery		
Tonsillectomy		
Appendectomy		
Cancer		
Other:		
Other:		
Other:		

Condition:	Explanation:



Orthopedic Injuries / Surgeries (within the past two years):

(i.e. Neck, Back, Shoulder, Arm, Elbow, Wrist, Hand, Finger, Hip, Leg, Knee, Ankle, Foot, Toe, etc.)

Injury:	Date(s):	Comments:

Please review the following areas of concerns. If you answer yes, please explain below.

Areas of Concern:	Yes	No
Have you ever been advised by a medical doctor to not participate in sport(s)?		
Have you had any injury / illness which required surgery or hospitalization?		
Do you have any pins, screws, or plates in your body (e.g. Spinal Fusion)?		
Do you require any special braces, splints, or pads for physical activities?		
Do you have any other medical concerns other than those listed previously?		

Explanation(s): _____

Drugs, Supplements, and Miscellaneous Agents:

Have you ever used the following:	Never	Occasionally	Frequently
Alcohol (Beer, Wine, Liquor, etc.)			
Cigarettes, Cigars, Pipes, Hookah, E-Cigs/Vapes			
Tobacco (Snuff, Chewing, Dip, etc.)			
Energy Drinks / Caffeine Drinks			
Weight Loss Pills			
Stimulants (Amphetamines, Cocaine, etc.)			
Depressants (Xanax, Opium, Heroin, etc.)			
Psychoactive / Hallucinogens (Ecstasy/MDMA, Cannabis/Marijuana, LSD, Peyote/Mescaline, etc.)			
Pre-Workout Supplements			
Performance-Enhancing Drugs (Anabolic Steroids, Creatine, Human Growth Hormone "HGH", etc.)			
Other:			
Other:			



Mental Health Concerns:

Do you, or have you, had any of the following conditions? If so, please explain below.

Condition:	Y	N
Stress Disorder		
Depression Disorder		
Anxiety Disorder		
Sleeping Disorder		
Mental Illness		
Suicidal Thoughts		
Attention Deficit with hyperactivity		
Attention Deficit without hyperactivity		

Condition:	Y	N
Feelings of Isolation / Loneliness		
Regularly Homesick		
Anger or Short Temper		
Mood Swings		
Constant Fatigue		
Low Self-Esteem		
Other:		
Other:		

Condition:	Explanation:

Female Concerns (Women Only):

Please review the following areas of concerns. If you answer yes, please explain below.

Areas of Concern:	Yes	No
Are your periods currently regular (every 24-35 days)?		
Have you had a history of period irregularity (too frequent, or absence of period)?		
Have you experienced amenorrhea (no periods for 3 months or more)?		
Is there a history of osteoporosis in your family?		
Do you have a history of fractures (e.g. stress fractures)?		

Explanation(s): _____

I certify that all the above information is true and accurate 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 intercollegiate athletics and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

Student Signature: _____ Date: _____

Parent Signature (if under 18): _____ Date: _____



Physical Examination Page 1 of 3

Name: _____ Today's Date: _____

Year in School (circle): Fresh. Soph. Jun. Sen. Grad. Sex (circle): Male Female

Sport(s): _____ Birthdate: _____ Age: _____

Must be completed by M.D. or D.O. (no exceptions)

Height: _____ Weight: _____ Body Composition: _____

Pulse: _____ Blood Pressure: _____ / _____ (_____ / _____, _____ / _____)

Vision: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal Unequal

Medical	Normal	Abnormal	Initial
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Pulses			
Lungs			
Abdomen			
Genitalia (Males only)			
Skin			
Dental			

Musculoskeletal	Normal	Abnormal	Initial
Neck			
Back			
Shoulders/Arms			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Posture			
Flexibility			
Strength			

Extended musculoskeletal exam on the following pages...



Physical Examination Page 2 of 3

Name: _____ Today's Date: _____

Sport(s): _____ Birthdate: _____ Age: _____

Left	Standing	Right
Limited mobility / Pain / Hypermobile	Shoulder Flexion	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Shoulder Abduction	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Shoulder ER Apley's	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Shoulder IR Apley's	Limited mobility / Pain / Hypermobile
Pain	Cross body Abd, then elbow to forehead	Pain
	Cervical Flex	Limited mobility / Pain / Hypermobile
	Cervical Ext	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Cervical SB	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Cervical Rot	Limited mobility / Pain / Hypermobile
	Trunk Flex	Limited mobility / Pain / Hypermobile
	Trunk Ext	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Trunk SB	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Trunk Rot	Limited mobility / Pain / Hypermobile
Genu Valgus / Not on Target / Pain	S/L hop in 1 spot 3x5	Genu Valgus / Not on Target / Pain

Left	Supine	Right
Limited mobility / Pain / Hypermobile	Hip 90/90 IR	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Hip 90/90 ER	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Hamstring 90/90	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	SKTC	Limited mobility / Pain / Hypermobile
Limited arc compared to right / Throwing Arm	Shldr IR/ER arc of motion	Limited arc compared to left / Throwing Arm
Limited mobility / Pain / Hypermobile	Shldr IR @ 90° abd	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Shldr ER @ 90° abd	Limited mobility / Pain / Hypermobile

	Prone	
Poor low abdominals / Lordosis Hip Drop R L	Plank	__ Min __ Sec __ % Scapular Winging R L
	Superman UE in Y not W	Core Weakness
	Press up / Cobra	Pain
Quad Tightness	Prayer Position	Pain
Pain	Duck Walk	Pain

18-25 years of age, collegiate self-described athletes mean time held in plank position is...

Females: 1 minute, 46.15 seconds

Males: 1 minutes, 57.66 seconds

Females: 25% = 1 min, 13.5 secs 50% = 1 min, 35 secs 75% = 2 mins, 2.5 secs

Males: 25% = 1 min, 24 secs 50% = 1 min, 50 secs 75% = 2 mins, 15 secs



Physical Examination Page 3 of 3

Name: _____ Today's Date: _____

Sport(s): _____ Birthdate: _____ Age: _____

Left		Beighton	Right	
0	1	Passive Extension 5th finger greater than 90 degrees	0	1
0	1	Passive Flexion of the thumb to the forearm	0	1
0	1	Hyperextension of the elbow beyond 10 degrees	0	1
0	1	Hyperextension of the knee beyond 10 degrees	0	1
0	1	Flexion of trunk w/ knees fully extended & palms on the floor	Score:	/9

Must be completed by M.D. or D.O. (no exceptions)

Circe: **Cleared** / **Not Cleared** Reason: _____

Recommendations / Restrictions / Limitations:

Name of the Physician (print/type): _____

Address: _____ Phone: _____

Physician Signature: _____

Medical Stamp Required →

