





# CATHOLIC GRADE SCHOOL SPORTS CONFERENCE MEDICAL HISTORY SHEET

STUDENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**CIRCLE YES OR NO (FURTHER DESCRIBE YES ANSWER TO THE RIGHT)**

- YES NO HISTORY OF HIGH BLOOD PRESSURE \_\_\_\_\_
  - YES NO HISTORY OF HEART OR BLOOD VESSEL DISEASE \_\_\_\_\_
  - YES NO LIVER OR KIDNEY PROBLEMS \_\_\_\_\_
  - YES NO PREVIOUS STROKES – C.V.A. \_\_\_\_\_
  - YES NO DIABETES \_\_\_\_\_
  - YES NO EPILEPSY \_\_\_\_\_
  - YES NO RESPIRATORY DIFFICULTIES \_\_\_\_\_
  - YES NO BROKEN BONES \_\_\_\_\_
  - YES NO SENSORY DISTURBANCES \_\_\_\_\_
  - YES NO ARTHRITIS OR JOINT PROBLEMS \_\_\_\_\_
  - YES NO SPECIAL DIET RESTRICTIONS \_\_\_\_\_
  - YES NO PRESENTLY HAVE ANY METAL IMPLANTS \_\_\_\_\_
  - YES NO PRESENTLY HAVE A PACEMAKER \_\_\_\_\_
  - YES NO ANY PRESENT VISUAL PROBLEMS \_\_\_\_\_
  - YES NO ANY PRESENT HEARING PROBLEMS (HEARING AID) \_\_\_\_\_
  - YES NO ANY UNUSAL REACTION TO HEAT OR COLD \_\_\_\_\_
  - YES NO ANY ALLERGIES \_\_\_\_\_
  - YES NO CONCUSSIONS (LIST DATES) \_\_\_\_\_
- LIST CURRENT MEDICATIONS \_\_\_\_\_
- \_\_\_\_\_

LIST PREVIOUS MAJOR HOSPITALIZATION/SURGERIES \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
PARENT OR GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

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**PHYSICAL EXAM BY PHYSICAN**

Height (inches) \_\_\_\_\_  
Blood Pressure \_\_\_\_\_  
Vision \_\_\_\_\_

Weight (pounds) \_\_\_\_\_  
Pulse \_\_\_\_\_  
Contacts/glasses \_\_\_\_\_

WNL ABN

WNL ABN

HEENT \_\_\_\_\_  
 NECK \_\_\_\_\_  
 LUNGS \_\_\_\_\_  
 HEART \_\_\_\_\_  
 ABDOMEN \_\_\_\_\_  
 GENITALS \_\_\_\_\_  
 SKIN \_\_\_\_\_  
 NECK \_\_\_\_\_  
 SPINE \_\_\_\_\_  
 SHOULDER \_\_\_\_\_  
     STABILITY \_\_\_\_\_  
     IMPINGEMENT \_\_\_\_\_  
 ELBOW \_\_\_\_\_  
 WRIST \_\_\_\_\_  
 HAND \_\_\_\_\_  
 HIP \_\_\_\_\_

ANKLE \_\_\_\_\_  
     ALIGNMENT \_\_\_\_\_  
     STABILITY \_\_\_\_\_  
 FEET \_\_\_\_\_  
 KNEE \_\_\_\_\_  
 MCL \_\_\_\_\_  
 LCL \_\_\_\_\_  
 ACL \_\_\_\_\_  
 PCL \_\_\_\_\_  
 MENISCUS \_\_\_\_\_  
 PATELLA \_\_\_\_\_  
 PAIN \_\_\_\_\_  
 APPREHENSION \_\_\_\_\_  
 CREPITATION \_\_\_\_\_  
 FUNCTIONAL TEST \_\_\_\_\_  
 ONE LEG HOP \_\_\_\_\_  
 FULL SQUATS \_\_\_\_\_

NEEDS FURTHER EVALUATION                      YES                      NO  
 CLEARED FOR PARTICIPATION                    YES                      NO  
 COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN'S/NURSE PRACTITIONER'S/PHYSICIAN'S ASSISTANT'S SIGNATURE

\_\_\_\_\_  
DATE