

University of Sioux Falls

in conjunction with
Sanford Orthopedics and Sports Medicine



Health History and Physical Examination (please use ink) Date:

Name _____ Sport _____ Gender: M / F

Social Security Number _____ Date of Birth _____ Age _____

Permanent/Parents Address _____
Street City State Zip

Parent's Home Phone () _____ Work Phone () _____

School Address _____
Street City State Zip

Cell Phone () _____ School Phone () _____

Whom shall we contact in case of emergency? _____

Relation: _____ Home # () _____ Cell # () _____

Address: _____
Street City State Zip

Player Signature

Release of Medical Records

I, _____, hereby request and authorize any medical facility and/or organization listed, to release all information (including but not limited to history and physical, laboratory reports, x-ray reports, operative reports, discharge summaries, ER reports, and cardiovascular reports) included in my complete medical record to:

Head Athletic Trainer, University of Sioux Falls
1210 West 18th Street, Suite LL01
Sioux Falls, SD 57104

I release the above named person from all legal responsibility or liability that may arise from the act I have authorized. This authorization shall be in effect for one year from this date. I also agree to sign future releases of medical records as may be needed in order to process any claims that may be filed.

Player Signature

Date

Medical Staff Representative

Date

Medical Questionnaire

Instructions: This form is for your benefit. You **MUST** disclose all injuries whether you consider them to have been serious or minor. Answer all of the questions. Fully explain questions where required (those answered YES). List dates, procedures, hospitals, physicians and other pertinent information where appropriate.

Please list all inpatient and outpatient surgeries including arthroscopies you have had:

Date	Procedure	Physician	City, State
Example. 3/3/99	Cartilage Repair (Left Knee)	Dr. Jones	Dallas, Texas

Current Medication (including over the counter medications)

Medication	Dose/Frequency	Duration of Use	Reason
Example. Ibuprofen	600 mg/ 3X Day	Since March 1999	Swelling, Pain

Current Vitamins or Supplements (example: Creatine, Vitamins)

Supplement	Dose/Frequency	Duration of Use	Reason
Example. Ripped Fuel	6 tablets/day	Since March 2003	Weight Loss

Do you have any ongoing or chronic illness or injury? If yes, please explain. YES NO

Have you been told to have a surgery that you have not had? If yes, please explain. YES NO

Internal Medical History

To your knowledge, were you born with a complete and functional set of paired organs (example eyes, ears, kidneys, testicles, lungs)? YES NO

If not, what organ(s) are involved? _____

Have you ever had surgery to repair or remove any organ (example: hernia, appendix) YES NO

If yes, what organ(s) _____

General Medical Health History

Have you **EVER** had or are you currently experiencing any of the following conditions?

	YES	NO		YES	NO
Rheumatic fever			Appendicitis		
Scarlet fever			Constipation		
Malaria			Frequent or bloody diarrhea		
Chickenpox			Colitis or bowel disease		
Hepatitis (jaundice)			Hemorrhoids or rectal bleeding		
Meningitis			Liver or gallbladder disease		
Tuberculosis			Kidney or gall stones		
Gonorrhea or syphilis			Difficulty or pain urinating		
Herpes (Oral)			Passed blood or pus in urine		
Herpes (Genital)			Kidney or bladder infections		
Other sexually transmitted diseases			Hernia		
Mumps			Frequent headaches		
Measles			Migraine headaches		
Rubella			Concussions/ knocked out		
Frequent skin infections or boils			Epilepsy (seizures)		
Sinusitis			Heat exhaustion or heat stroke		
Frequent sore throat			Diabetes		
Upper respiratory infections			Thyroid trouble		
Pneumonia			Anemia		
Asthma			Sickle cell disease or trait		
Frequent cough after exercise			Gout		
Wheezing or shortness of breath			Cancer (tumor, growth, cyst)		
Chest pain with exercise			Mononucleosis		
Fainted/ passed out			Arthritis, joint inflammation		
Rash or hives after exercise			Abnormal bruising or bleeding		
High blood pressure			Muscular disease		
Low blood pressure			Blood disease or clots		
Irregular heart beat			Eating disorders		
Racing heart (fast heart beat)			Eye disease, injury, vision loss		
Heart murmur			Ear disease, injury, hearing loss		
Dizziness			Ear infections		
Frequent indigestion			Ruptured organs		
Stomach or peptic ulcer			Problems with anesthesia		
Depression, anxiety, excessive worry			Car, train, sea, air sickness		
Currently using a habit forming drug			Mental illness or addiction		

Comments:

Family History

	Mother	Father	Brother(s)	Sister(s)	Other
If alive, list age(s)					
If deceased, list age when occurred					
Heart Disease					
Stroke					
High blood pressure					
Diabetes					
Mental illness					
Blood diseases (sickle cell, anemia)					
Other (Cancer, seizure, etc.)					
Has any family member died of a heart disease before the age of 40 ?				YES	NO

Allergies

Are you allergic to ...?	YES	NO	If YES, please explain the reaction
Asprin			
Anti-inflammatories			
Cortisone			
Codeine			
Penicillin			
Sulfa			
Other antibiotics			
Any other drug			
Tetanus antitoxin or serums			
Pollen, trees, grasses			
Seasonal/Hay Fever			
Insects bites/stings			
Latex			
Any Foods			
Others			

Comments:**Cardiac/ Heart Problems**

Have you ever experienced any of the following?	YES	NO
Felt dizzy, light-headed or passed out during or after exercise		
Chest pain while exercising		
Irregular heart beats or palpations		
Have you ever been told you have a heart murmur?		
Have you ever been seen by a heart specialist (cardiologist)?		
- If yes, who? Date?		
Have you ever had an echo-cardiogram or EKG?		
Have you ever had a stress (heart) test or exam?		

Comments:**Dental**

	YES	NO
Do you have a bridge or false teeth?		
Have you had a tooth knocked out?		
Do you wear a mouth protector?		
Do you wear orthodontic appliances?		

Comments:**Vision**

	YES	NO
Have you ever been to an eye doctor?		
Do you wear glasses or contacts?		
- If yes, while playing?		

Comments:

Heat Illness

Have you ever experienced any of the following?	YES	NO
Trouble with dehydration (excessive loss of salt and water)		
Heat exhaustion or heat stroke		
Heat cramps (due to fluid loss in excessive heat)		
Missed any practices or games due to heat illness or dehydration		
Been hospitalized for heat illness		

Comments:**Concussion**

						YES	NO
Have you ever had a concussion? ; If yes , how many? _____							
Have you ever been knocked unconscious? ; If yes, how many times? _____							
Have you ever been hospitalized for a head injury?							
If you answered yes to any of the above please give details including dates of concussions or loss of consciousness, results of any tests (CAT/CT, MRI), length of symptoms, hospitalization, & how many days missed.							
Date	Loss of Conscious	Tests performed	Hospitalization Required	Length of Symptoms	Days Missed		

Comments:**Females Only:**

			YES	NO
Have you ever had a menstrual period?				
Have you ever gone for more than 3 months without having a menstrual period?				
How old were you when you had your first menstrual period?				
How many periods have you had in the last 12 months?				
Have you ever had a gynecology exam? (Pap Smear)				
Have you had a gynecology exam (Pap Smear) within the last year?				

Comments:

Orthopedic Injuries and Exam

Do you have a history of any of the following injuries? Please note that the physician will fill out the right side of the form.

YES	NO	Injury	Normal	Abnormal	
		CERVICAL SPINE AND NECK			
		Neck Sprain or Strain			
		Cervical Spine Fracture			
		Herniated Disc in the Neck			
		Cervical Stenosis			
		THORACIC SPINE—UPPER BACK AND CHEST			
		Fractured Rib			
		Rib Cartilage Injuries			
		Pneumothorax			
		LUMBAR SPINE—LOWER BACK AND ABDOMEN			
		Low Back Pain, Spasms, Sprain, or Strain			
		Back Injury Causing Pain in Your Legs			
		Disc Herniation or Bulge			
		Spondylolysis or Spondylolisthesis			
		Abdominal Strains			
		Bruises to Internal Organs (kidney, liver, spleen, heart)			
How often do you experience back pain?(check the box below answer)		Never	Occasionally	Frequently	Only after exercise or heavy lifting

If you answered yes to any of the above, please give details.

YES	NO	Injury	Normal	Abnormal
		SHOULDERS		
		AC Sprain or Separation		
		Fractured Clavicle		
		Shoulder Subluxation		
		Shoulder Dislocation		
		Rotator Cuff Strain or Tear		
		Impingement Syndrome		
		Bursitis		
		Labral Tear		
		Biceps Tendon Injury		
		UPPER ARM AND ELBOW		
		Fractured Humerous or Elbow		
		Elbow or Bicep Tendinitis		
		Elbow Sprain		
		Elbow Dislocation		
		Ulnar Collateral Ligament (UCL) Sprain		
		Arthritic Changes or Bone Spurs in your elbow		
		FOREARM, WRIST, HAND, AND FINGERS		
		Fractured Hand, Wrist or Forearm		
		Sprain or Dislocation of Wrist		
		Sprain of Fingers or Thumb		
		Dislocations or Fractures of Finger or Thumb		

If you answered yes to any of the above, please give details.

YES	NO	Injury	Normal	Abnormal
		HIP AND PELVIS		
		Hip Bruise or Hip Pointer		
		Sprain, Strain or Dislocation of the Hip		
		Groin or Hip Flexor Strain		
		Osteitis Pubis		
		THIGH		
		Thigh Contusion		
		Hamstring Strain or Quad Strain		
		Fractured Femur		
		Calcium Deposit in Thigh		

If you answered yes to any of the above, please give details.

YES	NO	Injury	Normal	Abnormal
		KNEE		
		Swelling of the Knee		
		Sprained or Torn Ligaments in the Knee(ACL,PCL,MCL,LCL)		
		Torn Meniscus or Cartilage		
		Arthroscopic Surgery to the Knee		
		Arthritis or Arthritic Changes to the Knee		
		Cortisone Injection to the Knee		
		Patellar Tendinitis		
		Subluxation or Dislocation of the Patella		
		LOWER LEG		
		Shin Splints		
		Calf Strain or Pull		
		Fractured Tibia or Fibula		
		Achilles Tendonitis, Stain, or Rupture		
		ANKLE		
		Ankle Sprain or Strain		
		Fracture or Dislocation of the Ankle		
		Arthritis or Arthritic Changes in the Ankle		
		FOOT AND TOES		
		Sprain or Strain to Foot		
		Fractures or Stress Fractures to Foot		
		Plantar Fascia		
		Arthritic Changes in Foot		
		Toe Sprain, or Strain (Including Turf Toe)		
		Fractures or Dislocations to Toes		
		Bunions		

If you answered yes to any of the above, please give details.

YES	NO	
		Have you had any other injuries to bones, joints, muscle, tendon, nerves, or body tissue or body systems that you have not been asked about?
		Are you presently under the care of a physician or other health professional (optician, dentist, psychiatrist, etc.) for any problem?

If you answered yes to any of the above, please give details.

Medical Examination

The following needs to be completed by the team medical staff/team physician.

Height: _____ Weight _____ Body Fat% _____

Blood Pressure: _____ Retake: _____ Pulse: _____

Vision: Both _____ Right _____ Left _____ Corrected: YES NO

	Normal	Abnormal	Comments
General Appearance			
Head			
Eyes, Ears, Nose			
Mouth/Throat			
Neck			
Thorax/Lungs			
Cardiovascular			
Abdomen			
Skin			
Neurological			
Mental Status			

Orthopedic Screen

	Normal	Abnormal	Dr Check	Comments
Neck				
Shoulder				
Elbow				
Wrist				
Hand				
Back				
Hip				
Knee				
Ankle				
Foot				

Physician's Summary/Recommendations:

- Cleared without concerns
- Cleared with recommendations: _____

- Not Cleared until further evaluation or treatment: _____

- Not Cleared for certain sports: Sport: _____
- Not Cleared for all sports

Physician's Signature

Date