**Boston Mountain Rural Health Inc.**

**934 N. Gaskill Street, Huntsville, AR 72740**

Date\_\_\_\_\_\_\_\_\_\_\_ Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_

*(Circle One)* Male *or* Female Grade \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sports you participate in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s)/Guardian(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street or P.O. Box City State Zip Code

***Past Medical History Circle “Yes” or “No”***

*Have you had or do you have? Females Only*

Surgery Yes No Age when first menstrual period

Dizziness Yes No began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Pain Yes No Date of your last menstrual period:

Heart Murmur Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Racing Heart or Skipped Beats Yes No Excessive flow? Yes No

Asthma / Wheezing Yes No Spotting between periods? Yes No

Seizures Yes No

Muscle Cramps Yes No

Eye Problems Yes No

Allergies / Swelling or reactions to insect stings or other substances? Yes No

Have you ever been hospitalized or gone to the ER? Yes No

Have you ever had a head injury, been knocked out or unconscious? Yes No

Do you tire more quickly than your friends during exercise? Yes No

Do you have trouble breathing or coughing during or after activities? Yes No

Do you use any special equipment? *(Braces, knee pads, neck roll, etc)*  Yes No

Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? Yes No *(If so, circle the area below in which it occurred)*

 Head Shoulder Thigh Neck Elbow Knee Chest Forearm

 Back Wrist Ankle Hip Hand Foot Shin/Calf Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last Tetanus shot?\_\_\_*\_\_\_\_\_\_\_\_\_\_\_(Date)* Measles Immunization?\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(Date)*

Do you have any medical problems? Yes No *If yes, please explain:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications or pills? Yes No

**I hereby state that, to the best of my knowledge, the answers above are correct and complete.**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Signature of Athlete Signature of Parent/Guardian*

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HEENT: NL\_\_\_\_\_\_\_ABNL\_\_\_\_\_\_\_\_\_\_\_ NECK: NL\_\_\_\_\_\_\_ABNL\_\_\_\_\_\_\_\_\_\_

CHEST: NL\_\_\_\_\_\_\_ABNL\_\_\_\_\_\_\_\_\_\_\_ ABD: NL\_\_\_\_\_\_\_ABNL\_\_\_\_\_\_\_\_\_\_

G.U. NL\_\_\_\_\_\_\_ABNL\_\_\_\_\_\_\_\_\_\_\_ EXT: NL\_\_\_\_\_\_\_ABNL\_\_\_\_\_\_\_\_\_\_

ASSESSMENT: HT: \_\_\_\_\_\_\_\_\_\_\_ WT \_\_\_\_\_\_\_\_\_\_\_

 VISION(L)\_\_\_\_\_\_\_\_\_\_ (R)\_\_\_\_\_\_\_\_\_\_\_

COMMENTS: B/P\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.D.