RIVERSIDE MEDICAL CLINIC
SPORTS MEDICINE

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PRE - PARTICIPATION SPORTS SCREENING

Name _____ Age _____ Gender _____ Date of Birth _____

Address _____ Phone _____

School _____ Grade _____ Sports _____

Height _____ Weight _____ Personal Physician _____ Physician's Phone _____

Medical History Questionnaire - This section must be completed before your examination. Include dates/age of any problems and explain ALL "Yes" answers in the space below the questions.

		YES	NO
1.	Do you have any ongoing medical conditions? ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Other: _____	☐	☐
2.	Have you ever spent the night in a hospital?	☐	☐
3.	Have you ever had surgery?	☐	☐
4.	Are you currently taking any medications or pills?	☐	☐
5.	Do you have any allergies (medicine, bee stings, etc.)?	☐	☐
6.	Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
7.	Have you ever had chest pains DURING or AFTER exercise?	☐	☐
8.	Have you ever had high blood pressure?	☐	☐
9.	Have you ever been told you have a heart murmur?	☐	☐
10.	Does your heart ever race or skip beats (irregular beats) during exercise?	☐	☐
11.	Has any family member died of heart problems or had an unexplained sudden death BEFORE age 50?	☐	☐
12.	Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐
13.	Have you ever had a seizure?	☐	☐
14.	Have you ever had a head injury or concussion?	☐	☐
15.	Have you ever been knocked unconscious?	☐	☐
16.	Do you have headaches with exercise?	☐	☐
17.	Do you have any problems with your eyes or vision? Do you wear ☐ Glasses ☐ Contacts ☐ Eye Protection?	☐	☐
18.	Do you have only one working organ of usually paired organs (such as only one eye, kidney, testicle, etc.)?	☐	☐
19.	Have you ever had a sprained, broken, dislocated or repeated swelling or pain of any bones or joints that caused you to miss a practice or game?	☐	☐
20.	Are any joints CURRENTLY bothering you? ☐ Neck ☐ Back ☐ Shoulder ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Hip ☐ Thigh ☐ Knee ☐ Shin/Calf ☐ Ankle ☐ Foot	☐	☐
21.	Do you use any special equipment (splints, neck rolls, mouth guards)?	☐	☐
22.	Have you ever had a stinger, burner or pinched nerve?	☐	☐
23.	Have you ever been told you have Sickle Cell Trait or Sickle Cell Disease?	☐	☐
24.	Have you had any medical problems or injuries since your last evaluation?	☐	☐
25.	Has a doctor ever Denied or Restricted your participation in sports for any reason? When and why? _____	☐	☐
26.	When was your last tetanus vaccine? _____		
	(FEMALES ONLY)		
27.	Have you ever had a menstrual period?	☐	☐
28.	If so, how old were you when you had your first menstrual period? _____		
29.	How many periods have you had in the last 12 months? _____		
30.	What was the longest time between our periods last year? _____		

Explain all "Yes" answers by question number and indicate date/age for each item (Example: #3: Right arm fracture in 2015):

_____

_____

_____

_____

I/We hereby state that, to the best of my/our knowledge, the answers to the above questions are correct. I/We understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this Individual.

Signature of Athlete _____ Date _____

Signature of Parent or Guardian (if athlete is under 18) _____ Date _____

	Blood Pressure	HEENT	Skin	Heart	Lungs	Musculoskeletal	Flexibility/Strength
NORMAL							
ABNORMAL							

While this does not constitute a complete physical examination nor replace the need for periodic health evaluations by a pediatric or family physician, this individual appears to be physically capable of participation in interscholastic sports as of this date, except as indicated below:

☐ **CLEARED** for all sports without restrictions

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ NOT Cleared:

At this athlete's screening exam, the following is/are noted, and require further evaluation prior to participating in athletics:

☐ Elevated Blood Pressure

☐ Heart Murmur

☐ Other: _____

Physician's Name: _____ Date of examination: _____

Address: _____

City/State/Zip: _____ Physician's Signature: _____, MD or DO

Scan into EHR