RIVERSIDE MEDICAL CLINIC
SPORTS CLINIC

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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 of any problems and explain all yes answers. Please sign In appropriate spaces below.

		YES	NO
1.	Are you currently under a doctor's care for any reason?	☐	☐
2.	Have you ever been hospitalized?	☐	☐
3.	Have you ever had surgery?	☐	☐
4.	Are you currently taking an medications or pills?	☐	☐
5.	Do you have any allergies (medicines, bee stings, etc.)?	☐	☐
6.	Have you ever been dizzy or fainted 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.	Have you ever had a racing heart or skipped heartbeats?	☐	☐
11.	Have you ever had a head injury or concussion?	☐	☐
12.	Have you ever been knocked unconscious?	☐	☐
13.	Have you ever had a seizure?	☐	☐
14.	Are any of the following currently bothering you?	☐	☐
	Hand ☐ Wrist ☐ Elbow ☐ Forearm ☐ Hip ☐		
	Thigh ☐ Knee ☐ Ankle ☐ Shin/Calf ☐ Foot ☐		
15.	Have you ever been dizzy or passed out due to the heat?	☐	☐
16.	Do you have trouble breathing before or after exercise?	☐	☐
17.	Have you had any problems with your eyes or vision?	☐	☐
18.	Do you wear glasses or contacts or protective eye wear?	☐	☐
19.	Do you use any special equipment (splints, neck rolls, mouth guards, etc.)?	☐	☐
20.	Has anyone in your family died of heart problem or sudden death before the age of 50?	☐	☐
21.	Do you have only one working organ of usually paired organs (only one eye, kidney, etc.)?	☐	☐
22.	Have you ever sprained, broken, dislocated or had repeated swelling or pain of any bones or joints?	☐	☐
23.	Have you ever had a stinger, burner or pinched nerve?	☐	☐
24.	Have you had any medical problems or injuries? (asthma, mono, diabetes, etc.)	☐	☐
25.	Have you had any medical problems or injuries since your last evaluation?	☐	☐
26.	Were there any special instructions or precautions given by the Medical Practitioner?	☐	☐
27.	What was the date of your last tetanus shot _____		
28.	Do you have Sickle Cell Trait or Sickle Cell Disease?	☐	☐
29.	(Women Only) Date of first menstrual period: _____ Date of your last menstrual period: _____ What was the longest period of time between your periods last year? _____		

Explain all "Yes" answers by question number and indicate dates for each item (include any special instructions):
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	Abdomen	Flexibility/Strength
NORMAL							
ABNORMAL							

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

☐ Cleared for sports without restrictions: _____

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not Cleared

At this athlete's screening exam, the following is/are noted:

Condition/Sign/Symptoms with Simple Explanation/Recommendations

☐ Elevated (High) Blood Pressure. Increase in pressures in the artery during the beating and resting heart. Maximum normal (age group) __ / __

☐ Heart Murmur. Flow of blood through the heart which is audible. In this case, it is: 0 "Functional" (normal) 0 Abnormal.

☐ Asthma. Blockage of small airways in the lung. ☐ Use inhaler as prescribed and 30 minutes before exercise.

☐ Allergic Reactions to Stings or Bites. (includes whole body swelling & shortness of breath) ☐ Epinephrine injector should be available at all times.

☐ Diabetes. Abnormal sugars and sugar metabolism. ☐ Continue close monitoring with M.D.

☐ Scoliosis. Curvature of the spine. ☐ Continue close monitoring with M.D.

☐ Orthopaedic Problem. Being seen by M.D. for this condition. ☐ Should be cleared for play by M.D.

☐ Concussion. Further evaluation required before athletic participation permitted.

☐ Other: _____

Physician's Name: _____ Physician's Signature: _____ Date: _____

Scan into EHR