



## CATHOLIC GRADE SCHOOL SPORTS CONFERENCE MEDICAL HISTORY SHEET

STUDENT'S NAME: \_\_\_\_\_ Date: \_\_\_\_\_

**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
HEENT _____		
NECK _____		
LUNGS _____		
HEART _____		
ABDOMEN _____		
GENITALS _____		
SKIN _____		
NECK _____		
SPINE _____		
SHOULDER _____		
STABILITY _____		
IMPINGEMENT _____		
ELBOW _____		
WRIST _____		
HAND _____		
HIP _____		

	WNL	ABN
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 SIGNATURE

\_\_\_\_\_  
DATE