Kudo Care

—MEDICINE DENTAL VISION—

SPORT PHYSICAL EVALUATION FORM

NAME:____________________ ID#____________________ YEAR IN SCHOOL (CIRCLE ONE): FRESH SOPH JUNIOR SENIOR 5TH

CELL PHONE #:____________________ EMAIL:____________________ SPORT(S):____________________

DOB:__________ SEX: F M

Do you have any allergies? [] Yes [] No If yes, please identify specific allergy below:

[] Medicines [] Pollens [] Food [] Stinging insects [] Other

Medicines: List all prescription and over the counter medicines and supplements (herbal and nutritional) that you are currently taking:

____

____

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: [] Asthma [] Anemia [] Diabetes [] Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: [] high blood pressure [] heart murmur [] high cholesterol [] heart infection [] Kawasaki disease [] Other:		
9. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25 Any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	YES	N
26. Do you have asthma?		
27. Have you ever been diagnosed with depression or anxiety?		
28. Do you or have you ever had thoughts of suicide?		
29. Have you been diagnosed with ADHD or ADD?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
If yes, how many diagnosed concussions have you had? How much time did you miss for each concussion?		
35. Do you have a history of seizure disorder?		
36. Do you have headaches with exercise?		
37. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
38. Have you ever been unable to move your arms and legs after being hit or falling?		
39. Have you ever become ill while exercising in the heat?		
40. Do you get frequent muscle cramps when exercising?		
41. Were you born without or are missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
42. Have you had any problems with your eyes or vision?		
43. Have you had any eye injuries?		
44. Do you wear glasses or contact lenses?		
45. Do you wear protective eyewear, such as goggles or a face shield?		
46. Have you ever had a problem with alcohol or substance abuse?		
47. Are you trying to or has anyone recommended that you gain or lose weight?		
48. Are you on a special diet or do you avoid certain types of foods?		
49. Have you ever had or have an eating disorder?		
50. Do you have any concerns that you would like to discuss with a doctor or provider?		
Explain "YES" answers here:		
FEMALES ONLY		
51. Have you ever had a menstrual period?		
52. How old were you when you had your first menstrual period?		
53. How many periods have you had in the last 12 months?		

DATE____________________ Signed____________________ ©

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MEDICINE DENTAL VISION

Student Name:______________________________ Date of Exam: ______________

Height__________ Weight__________ BMI__________

BP_____/______ Pulse________ Vision R 20/_____ L 20/______ Corrected [] Yes [] No

	Normal	Abnormal Findings
Appearance *Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly,, arm span) height, hyperlaxity, myopia, MPV, aortic insufficiency)		
HEENT		
Heart *Murmurs (auscultation standing, supine, +/- Valsalva) *Location of point of maximal impulse (PMI)		
Pulses *Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
GU		
Skin *HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional *Duck-walk, single leg hop		

[] Cleared for all sports without restriction
[] Limited participation
[] No participation
[] Records requested for ____

The athlete does not present apparent clinical contraindications to practice and participation in the sport(s) as outlined above.

Examined by:____ Date __________

Supervising physician MD or DO ONLY signature:______________________________ Date__________

Physician's (MD or DO) Name printed ____________________ Address ______________________________

THIS SIDE FOR HEALTH SERVICE USE ONLY: