UL Lafayette Athletic Training Education Program

PHYSICAL EXAMINATION MEDICAL HISTORY QUESTIONNAIRE

NAME____ SEX_____
(LAST) (FIRST) (MI)
LOCAL
ADDRESS____ ___ ___ ___ ___ ___ ___ ___ ___ CITY______________STATE_____ZIP________________

SS #_____-_____-_____DATE OF BIRTH____/____/____LOCAL PHONE(____)______-_________

PERM. ADDRESS__________________________CITY______________STATE_____ZIP___________

PERM. PHONE(____)_____-_____

NOTIFY THE PROGRAM DIRECTOR IF THIS INFORMATION CHANGES

IN CASE OF AN EMERGENCY PLEASE NOTIFY:

NAME________________________________ RELATION___________________
(LAST) (FIRST)
ADDRESS ____________________ CITY______________ STATE_______ZIP_______
EMERGENCY PHONE NUMBER (____)_____-_________

PARENT OR GUARDIAN ADDRESS (IF DIFFERENT FROM ABOVE):

NAME________________________________ RELATION___________________
(LAST) (FIRST)
ADDRESS___________________CITY______________STATE________ZIP_______
EMERGENCY PHONE NUMBER (____)_____-_________

"STUDENT AGREES THAT HE/SHE HAS FULLY DISCLOSED TO THE TEAM PHYSICIAN ALL PRESENT OR PRIOR PHYSICAL OR MENTAL DEFECTS, ILLNESSES, INJURIES, CONDITIONS, OR INFORMATION OF WHICH HE/SHE HAS OR SHOULD HAVE KNOWLEDGE, WHICH MIGHT PREVENT, AFFECT, HINDER, OR IMPAIR HIS/HER PERFORMANCE. STUDENT FURTHER AGREES THAT HE/SHE HAS NOT WITHHELD NOR FAILED TO DISCLOSE ANY PRESENT OR PREVIOUS PHYSICAL OR MENTAL DEFECT, ILLNESS, INJURY, CONDITION, OR INFORMATION KNOWN TO HIM/HER."

___________________________________ ______________
SIGNATURE OF STUDENT **DATE**

PHYSICAL EXAMINATION MEDICAL HISTORY QUESTIONNAIRE

EXPLAIN "YES" ANSWERS BELOW AT BOTTOM OF PAGE!!

Yes No

O O 1. HAVE YOU EVER BEEN HOSPITALIZED?
O O a. HAVE YOU EVER HAD SURGERY?

O O 2. ARE YOU PRESENTLY TAKING ANY MEDICATIONS OR PILLS?

O O 3. DO YOU HAVE ANY ALLERGIES (MEDIC INE, BEE OR OTHER STINGING INSECT)?

O O 4. HAVE YOU EVER PASSED OUT DURING OR AFTER EXERCISE?
O O a. HAVE YOU EVER BEEN DIZZY DURING OR AFTER EXERCISE?
O O b. HAVE YOU EVER HAD CHEST PAIN DURING OR AFTER EXERCISE?
O O c. DO YOU TIRE MORE QUICKLY THAN YOUR FRIENDS DURING EXERCISE?
O O d. HAVE YOU EVER HAD HIGH BLOOD PRESSURE?
O O e. HAVE YOU EVER BEEN TOLD THAT YOU HAVE A HEART MURMUR?
O O f. HAVE YOU EVER HAD RACING OF YOUR HEART OR SKIPPED HEARTBEATS?
O O g. HAS ANYONE IN YOUR FAMILY DIED OR HEART PROBLEMS OR A SUDDEN DEATH BEFORE AGE 50?

O O 5. DO YOU HAVE ANY SKIN PROBLEMS (ITCHING, RASHES, ACNE)?

O O 6. HAVE YOU EVER HAD A HEAD INJURY?
O O a. HAVE YOU EVER BEEN KNOCKED OUT OR UNCONSCIOUS?
O O b. HAVE YOU EVER HAD A SEIZURE?
O O c. HAVE YOU EVER HAD A STINGER, BURNER OR PINCHED NERVE?

O O 7. HAVE YOU EVER HAD HEAT OR MUSCLE CRAMPS?
O O a. HAVE YOU EVER BEEN DIZZY OR PASSED OUT IN THE HEAT?

O O 8. DO YOU HAVE TROUBLE BREATHING OR DO YOU COUGH DURING OR AFTER ACTIVITY

O O 9. DO YOU USE ANY SPECIAL EQUIPMENT (PADS, BRACES, NECK ROLLS, MOUTH, EYE GUARD

O O 10. HAVE YOU HAD ANY PROBLEMS WITH YOUR EYES OR VISION?
O O a. DO YOU WEAR GLASSES OR CONTACTS OR PROTECTED EYE WEAR?

O O 11. HAVE YOU EVER SPRAINED/STRAINED, DISLOCATED, FRACTURED, BROKEN OR HAD REPEATED SWELLING OR OTHER INJURIES OF ANY BONES OR JOINTS?
O HEAD O SHOULDER O THIGH O NECK O ELBOW O KNEE O CHEST
O FOREARM O SHIN/CALF O BACK O WRIST O ANKLE O HIP O HAND O FOOT

O O 12. HAVE YOU HAD ANY OTHER MEDICAL PROBLEMS (INFECTIOUS MONONUCLEOSIS, DIABETES, ETC)?

O O 13. HAVE YOU HAD A MEDICAL PROBLEM OR INJURY SINCE YOUR LAST EVALUATION?

14. WHEN WAS YOUR LAST TETANUS SHOT?____________________________
a. WHEN WAS YOUR LAST MEASLES IMMUNIZATION? ____________________________

QUESTION # EXPLAIN "*YES*" ANSWERS:

____________ ____
____________ ____
____________ ____
____________ ____
____________ ____

Verification of Immunizations:

The student has provided you with documented proof of the following:

- A) Mumps _________Yes__________No
- B) Measles _________Yes__________No
- C) Rubella _________Yes__________No
- D) Tetanus _________Yes__________No
- E) HBV _________Yes__________No

(For HBV, answering yes can mean that the student has documented proof of completion of HBV series or has initiated the HBV series)

____
Physician Signature

ORTHOPEDIC EXAM

MUSCULOSKELETAL EVALUATION:

NECK, SHOULDER GIRDLE OR UPPER EXTREMITY______________ ___ ___ ___ ___
ABNORMALITIES?____
LIMITATION OF MOVEMENT?____________________________________

TRUNK____
RIB ABNORMALITIES?____

THIGH & KNEE_____ _______ ___ ___ ___ ___ _________________________________
HAMSTRING OR QUADRICEPS ABNORMALITIES?_ __ ___ ____ ___ ___ ___ _

KNEE LIGAMENT & STABILITY?__________________________________

CALF, ANKLE & FOOT____

ACHILLES TENDON DISORDER?__________________________________

ANKLE LIGAMENT STABILITY?__________________ ___ ___ ___ ___ ___ __

ANKLE JOINT EFFUSION OR CREPITATION?_______________________

FOOT PROBLEMS?____

LIMITATIONS OF MOVEMENT?___________________________________

DENTAL EVALUATION: (MISSING TEETH? CHIPPED TEETH?)____________________

HEIGHT________ ___ _______**WEIGHT**______________

INTERNAL CHECK

THORAX:

HEART____

IF ORGANIC DISEASE IS PRESENT, IS IT FULLY COMPENSATED?______________

BLOOD PRESSURE (SITTING): SYSTOLIC___________**DIASTOLIC**_____________

PULSE: BEFORE EXERCISE_______**TWO MINUTES REST AFTER EXERCISE**____
LUNGS:____

ABDOMEN:

SCARS________________**ABNORMAL MASSES**__________**TENDERNESS**_______

HERNIA: YES___**NO**___ **IF SO, WHERE?**__________________________________

GENITO-URINARY:
SCARS____________________**URETHRAL DISCHARGE**_____________________

REFLEXES:
RHOMBERG____

PUPILLARY_________**LIGHT R**____**L**_____**ACCOMMODATION R**_____**L**_____

KNEE JERKS: RIGHT: NORMAL________**INCREASED**__ _______**ABSENT**__ _____

LEFT: NORMAL________**INCREASED**________**ABSENT**_______

EXTREMITIES:

In your opinion, (see Program Technical Standards) is this individual mentally and phy sically capable of performing the duties of an athletic training student. ____ yes ____ no. If no, please list accommodations needed.

____
PHYSICIAN'S SIGNATURE

UL LAFAYETTE ATHLETIC TRAINING EDUCATION PROGRAM

RELEASE OF MEDICAL INFORMATION FORM

I, ____________________, AUTHORIZE ANY PHYSICIAN, DENTIST, OR OTHER MEDICAL PERSONNEL TO RELEASE ANY MEDICAL INFORMATION TO THE UL LAFAYETTE ATHLETIC TRAINING EDUCATION PROGRAM ADMSSIONS COMMITTEE.

STUDENT'S SIGNATURE ____________________________________

DATE ____________________________________