MIAA RECOMMENDED SPORTS CANDIDATE MEDICAL QUESTIONNAIRE

PART A ~ HISTORY

DATE of EXAM _____

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Grade_____ School _____ Sport(s) _____

Address _____ Tel _____

Physician _____ Tel _____

IN CASE OF AN EMERGENCY, CONTACT:

Name _____ Relationship _____ Tel (H) _____ (W) _____

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

		YES	NO
1.	Have you had a medical illness or injury since your last check up or sports physical?	❑	❑
2.	Have you ever been hospitalized overnight?	❑	❑
3.	Have you ever had surgery?	❑	❑
4.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	❑	❑
5.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	❑	❑
6.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	❑	❑
7.	Have you ever had a rash or hives develop during or after exercise?	❑	❑
8.	Have you ever passed out during or after exercise?	❑	❑
9.	Have you ever been dizzy during or after exercise?	❑	❑
10.	Have you ever had chest pain during or after exercise?	❑	❑
11.	Do you get tired more quickly than your friends do during exercise?	❑	❑
12.	Have you ever had racing of your heart or skipped heartbeat?	❑	❑
13.	Have you had high blood pressure or high cholesterol?	❑	❑
14.	Have you ever been told you have a heart murmur?	❑	❑
15.	Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
16.	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	❑	❑
17.	Has a physician ever denied or restricted your participation in sports for any heart problems?	❑	❑
18.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	❑	❑
19.	Have you ever had a head injury or concussion?	❑	❑
20.	Have you ever been knocked out, become unconscious, or lost your memory?	❑	❑
21.	Have you ever had a seizure?	❑	❑
22.	Do you have frequent or severe headaches?	❑	❑
23.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	❑	❑
24.	Have you ever had a stinger, burner, or pinched nerve?	❑	❑
25.	Have you ever become ill from exercising in the heat?	❑	❑
26.	Do you cough, wheeze, or have trouble breathing during or after activity?	❑	❑
27.	Do you have asthma?	❑	❑
28.	Do you have seasonal allergies that require medical treatment?	❑	❑

		YES	NO
29.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	❑	❑
30.	Have you had any problems with your eyes or vision?	❑	❑
31	Do you wear glasses, contacts, or protective eyewear?	❑	❑
32.	Have you ever had a sprain, strain, or swelling after injury?	❑	❑
33.	Have you broken or fractured any bones or dislocated any joints?	❑	❑
34.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	❑	❑

If yes, check appropriate box and explain below:

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin/Calf
Shoulder	Finger	Ankle
Upper Arm		Foot

		YES	NO
35.	Do you want to weigh more or less than you do now?	❑	❑
36.	Do you lose weight regularly to meet weight requirements for your sport?	❑	❑
37.	Do you feel stressed out?	❑	❑

38. Record the dates of your most recent immunizations (shots) for:
Tetanus _____ Measles _____
Hepatitis B _____ Chickenpox _____

FEMALES ONLY:

39. When was your first menstrual period? _____
40. When was your most recent menstrual period? _____
41. How much time do you usually have from the start of one period to the start of another? _____
42. How many periods have you had in the last year? _____
43. What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.

Signature of Athlete/Date _____ Signature of Parent-Guardian/Date _____

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PART B ~ PHYSICAL EXAMINATION

STUDENT *(Please print)* _____ Date of Birth_____

Height _____ Weight_____ % Body Fat *(optional)*_____ Pulse____ BP _____ / ____ (____ / ____ , ____/____)

Eyes: R20/_____ L20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Station-based examination only

PART C ~ CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

_____

_____

_____

Not cleared for: _____ Reason: _____

_____

_____

_____

Name of physician *(Please print):* _____

Signature of physician:_____ Date: _____

Address:_____ Tel: _____

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