LYONS TOWNSHIP HIGH SCHOOL
MEDICAL HISTORY AND PHYSICAL EXAM FORM FOR SPORTS

Name_____ Sex (circle): Male Female

Address_____Town_____

Emergency Phone_____ Birthdate_____ Age_____

Class (circle): 9 10 11 12 I.D. Number_____ Date_____

MEDICAL HISTORY MUST BE COMPLETED PRIOR TO PHYSICAL EXAM!!!

MEDICAL HISTORY					
GENERAL MEDICAL QUESTIONS	**YES**	**NO**	**ORTHOPEDIC QUESTIONS**		
Have you ever been hospitalized over night?			Have you ever sustained an injury/illness that required you to miss practice or games for more than two days?	**YES**	**NO**
Have you ever had any surgery?			Neck		
Have you had any serious injuries or accidents?			Shoulder		
Are you taking any medication?			Chest		
Do you have any allergies to medicine, food or bees?			Arm		
Have you had any severe allergic reactions?			Elbow		
Are there any serious illnesses in your immediate family?			Forearm		
Has any family member died of heart disease before 40?			Wrist		
Do you have any history of high blood pressure?			Hand		
Have you ever had a heart murmur or rheumatic fever?			Thumb		
Have you ever passed out during exercise?			Finger		
Do you ever feel a racing heart or skipped beats?			Back		
Do you ever get short of breath with minimal exercise?			Hip		
Do you have any history of asthma or wheezing?			Pelvis		
Have you ever sustained a head injury or concussion?			Thigh		
Have you ever been "knocked out"?			Groin		
Have you ever had seizures or convulsions?			Knee		
Do you ever get numbness or tingling?			Kneecap		
Do you have any abnormal weakness?			Leg		
Do you have deformities or birth defects?			Ankle		
Are you bothered with frequent headaches?			Foot		
Do you have any skin problems?			Toe		
Have you ever had diabetes or low blood sugar?			*Males Only:*		
Have you ever had hepatitis, yellow jaundice, liver disease?			Do you have any problems with your penis, scrotum or testicles?		
Have you ever had kidney or urinary problems?					
Have you ever had abdominal or bowel problems?			Do you have a hernia, rupture or bulging of abdomen?		
Have you ever had anemia, blood, or bleeding problems?			Have you had a sexually transmitted disease?		
Are you missing any organs (i.e. kidney, testicle, eye, etc.)?			*Females Only:*		
Do you have any dental bridges, plates or braces?			At what age did you have your first menstrual period?		
have you ever had eye problems or injuries?			When was your last menstrual period?		
Do you have any chronic ear problems or hearing loss?			Are your menstrual periods regular?		
			Have you had a sexually transmitted disease?		

Explain any "Yes" answers:_____

_____

To the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete_____**Date**_____**Signature of Parent/Guardian**_____**Date**_____

PHYSICAL EXAM					
Blood Pressure:		Height:		Weight:	
Pulse:	Respirations:	Vision: Right:	Left:	Corrected Right:	Corrected Left:

GENERAL EXAM	N	A	Comments	NEURO & ORTHOPEDIC EXAM	N	A	Comments
General Appearance (Nutrition)				Neurologic			
Head				neck			
Eyes (Pupils, Reaction, EOM)				Shoulder			
Ears (EAC'S. TM's)				Elbows			
Nose				Wrists			
Oropharnyx				hands			
Neck				Hips			
Lymphatics			(Physician's Initials)	Knees			
Chest				Ankles			
Heart				Spine/Scoliosis			(Physician's Initials)
Lungs				Other:			
Abdomen							
Organomegaly			(Physician's Initials)				
Male Genitalia Tanner							
Male Hernia							
Other:			(Physician's Initials)				

SIGN-OFF			
Full Participation	**Limited Participation**	**No Participation**	**Requires:**
Comments:			**Date:**
Physician:		**MD Signature:**	
Address:		**Phone:**	