

West Valley College Athletic Screening Examination

(This is not a substitute for a regular physical exam by your family doctor)

Date of Exam: _____

Name: _____ Age: _____ Birthdate: _____

SS#: _____ Sport(s): _____

Address: _____ Phone: _____

Street City State Zip

Health Insurance: _____ Family Doctor: _____

Father's full name: _____ Living: _____ Deceased: _____

Mother's full maiden name: _____ Living: _____ Deceased: _____

Parent's Address: _____ Phone: _____

Street City State Zip

Medical History

1. Have you ever had any injuries such as: (Please check yes or no, using space below to explain details and dates as appropriate)

	Yes	No		Yes	No		Yes	No		Yes	No
Skull Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Heat Stroke/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Painful Kneecap	<input type="checkbox"/>	<input type="checkbox"/>	Shin Splints	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Severe Dehydration	<input type="checkbox"/>	<input type="checkbox"/>	Locking or catching	<input type="checkbox"/>	<input type="checkbox"/>	Torn Cartilage	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bone or Fracture	<input type="checkbox"/>	<input type="checkbox"/>	of a joint			Deep Bruise	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Finger Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Joint Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	Injury to Internal Organ	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Strain/Pull	<input type="checkbox"/>	<input type="checkbox"/>	Leg/Foot Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Ligament Sprain	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

2. Do you have a history of any medical problems such as:

	Yes	No		Yes	No		Yes	No		Yes	No
Asthma/Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing/Tightness in Chest	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease, Boils Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Visual or Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs/ Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

3. Are you allergic to any medicines or environmental agents? If YES, explain. _____

4. Have you ever been hospitalized or had an operation or surgery? If YES, explain. _____

5. Females: Date of last menstrual period _____. Do you have any gynecological problems or concerns? If YES, explain. _____

6. Have you ever had X-rays, worn a cast, splint, or sling, or used crutches? If YES, explain. _____

7. Have you recently or currently taken any sports supplements/vitamins? If YES, explain. _____

8. Do you take any medication on a regular basis? If YES, which medications and for what medical problems? _____

9. Do you have any questions about your current health or additional information to share with the doctor? Please add here. _____

Athletic Screening Examination (This is not a substitute for a regular physical exam by your family doctor)

Name: _____ Height: _____ Weight: _____

Blood Pressure: _____ Pulse: _____ Glasses/Contact Lenses: Y N Vision: R 20/____ L 20/ _____

I. EXAMINATION

Normal Abnormal Check each item, giving details in space to right if abnormal or noteworthy.

MEDICAL EXAM

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. General appearance (fitness, body fat) |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. HEENT (pupils, ears, nose, mouth, teeth, throat) |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Chest (chest wall, breath sounds) |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Cardiac (pulses, rhythm, murmur) |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Abdomen (liver, spleen, masses) |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Genitourinary (hernia, testes) |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Skin (rash, jaundice) |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Neurologic (CNS, DTR's, sensation) |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Other |

MUSCULOSKELETAL EXAM

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Spine (deformity, tenderness, motion, strength) |
| <input type="checkbox"/> | <input type="checkbox"/> | a. cervical |
| <input type="checkbox"/> | <input type="checkbox"/> | b. thoracic |
| <input type="checkbox"/> | <input type="checkbox"/> | c. lumbar |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Upper extremity (deformity, tenderness, motion, strength, stability) |
| <input type="checkbox"/> | <input type="checkbox"/> | a. AC joint/clavicle |
| <input type="checkbox"/> | <input type="checkbox"/> | b. shoulder |
| <input type="checkbox"/> | <input type="checkbox"/> | c. elbow |
| <input type="checkbox"/> | <input type="checkbox"/> | d. wrist |
| <input type="checkbox"/> | <input type="checkbox"/> | e. hand |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Lower extremity (deformity, tenderness, flexibility, strength, stability) |
| <input type="checkbox"/> | <input type="checkbox"/> | a. hip |
| <input type="checkbox"/> | <input type="checkbox"/> | b. knee (MCL, ACL, PCL, menisci) |
| <input type="checkbox"/> | <input type="checkbox"/> | c. leg (hams, quads, gastroc) |
| <input type="checkbox"/> | <input type="checkbox"/> | d. ankle (talar tilt, drawer) |
| <input type="checkbox"/> | <input type="checkbox"/> | e. foot |

II. FINDINGS/PROBLEMS:

- | | <u>Diagnosis</u> | <u>Treatment Recommendations</u> |
|----|------------------|----------------------------------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |

III. DISPOSITION:

- 1. Cleared for collision, contact, non-contact sports.
- 2. Conditional participation, limited to: _____
- 3. No participation until: _____
- 4. No participation in any sport because of: _____

Physician's Signature: _____ Date: _____