Marygrove College
Pre-participation Physical Examination Health History Form

Student's Last Name:____________________________________ First Name:____
Date of Birth:_________________________ Sex:_____________ Age:____________
Place of Birth:______________________________________
Student's Address:____
City:____ Zip:______________ Phone:_________________________________
Parent(s) or Guardian(s) Name:____
Family Physician's Name:____

HEALTH HISTORY – This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks. **Must be completed before physical examination**.
Explain "YES" answers below. Circle questions you do not know the answer to.

____
Student's Signature Date

Question	YES	NO
1. Have you had a medical illness since your last checkup or sports physical?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
4. *Do you think you are in good health?*	☐	☐
5. Do you have any allergies? (Food, pollen, medicine, or insect stings?	☐	☐
6. Have you ever had a rash or hives develop during or after exercise?	☐	☐
Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy before or during exercise?	☐	☐
Have you ever had chest pains before or during exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)?	☐	☐
Have you had a severe heart infection (for example myocarditis or pericarditis)?	☐	☐
Is there a family history of Marfan's Syndrome?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problem?	☐	☐
7. Have you ever had a severe viral infection within the last month? (for example Mononucleosis)	☐	☐
8. Do you have any current skin problems (itching, rashes, acne, warts, fungus or blisters)?	☐	☐
9. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
Have you had a stinger, burner or pinched nerve?	☐	☐
10. Have you ever become ill from exercising in the heat?	☐	☐
11. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
12. Do you use special protective or corrective equipment or devices that aren't usually used for your sport or position (knee brace, neck roll, foot orthotic, retainer for teeth, hearing aid)?	☐	☐
13. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts of protective eyewear?	☐	☐
14. Have you ever had a sprain, strain or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, check the appropriate box and explain

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

Question	YES	NO
15. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
16. Do you feel stressed out?	☐	☐

17. Record the dates of your most recent immunizations (shots) for:
Tetanus_____________________MMR_________________________
HepatitisB__________________Chickenpox____________________

18. FEMALES ONLY
When was your first menstrual period?__________________________
When was your most recent menstrual period?____________________
How much time do you usually have from the start of one period to the start of another?_______________________
How many periods have you had in the last year?____
What was the longest time between periods in the last year?____

19. ALL PARTICIPANTS
Explain YES answers here:__________________________________
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____

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Physician Signature Date

8425 W. McNichols Rd. • Detroit, MI • Office (313) 927-1391 • Fax (313) 927-1696

Body Part	Normal	Abnormal	Comments
Neck			
Spine			
Shoulders			
Upper Arm			
Elbow			
Lower Arm			
Hand			
Wrist			
Pelvis			
Hip			
Thigh			
Knee			
Lower Leg			
Ankle			
Foot			

Comments: ____

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Ht__________ Wt_________ BP_____/______ Pulse______ Vision: R 20/_____ L 20/_______

System	Normal	Abnormal	Comments
Ears			
Nose			
Throat			
Chest			
Heart			
Lungs			
Abdomen			

Comments:____

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The following is the outcome of the physical:

_____________Cleared for competition for the 2011-12 school year.

_____________Cleared for competition for the 2011-12 school year. Please see recommendations below.

_____________NOT cleared for competition for the 2011-12 school year. The following action should be taken.

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Physician Signature Date