FRASSATI CATHOLIC HIGH SCHOOL
MEDICAL HISTORY FORM

STUDENT NAME: _____ DATE OF BIRTH:_____

All Frassati Catholic Athletes and New Students are required to complete the Physical Form. The Medical History Form is part of the Physical and must be presented to the physician at the time of the Physical Examination. Explain "Yes" answers at end of form. Circle questions for which you do not know the answers. STUDENT, PARENT, AND PHYSICIAN ALL MUST SIGN THIS FORM

The student, with the help of a parent or guardian, is to answer the following questions:

1.	Have you had a medical illness or injury since your last check up or sports physical?	Y / N	
2.	Have you been hospitalized overnight in the past year?	Y / N	
3.	Have you had surgery in the past year?	Y / N	
4.	Are you currently taking any prescriptions or non-prescription(over the counter) medication or pills or using an inhaler?	Y / N	
5.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	Y / N	
6.	Have you ever passed out during or after exercise?	Y / N	
7.	Have you ever been dizzy during or after exercise?	Y / N	
8.	Have you ever had chest pain during or after exercise?	Y / N	
9.	Do you get tired more quickly than your friends during exercise?	Y / N	
10.	Have you ever had a racing of your heart or skipped heartbeats?	Y / N	
11.	Have you ever been told you have a heart murmur?	Y / N	
12.	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	Y / N	
13.	Has any family member been diagnosed with an enlarged heart, hypertrophic cardiomyopathy, long QT Syndrome, Marfan's Syndrome, or abnormal heart rhythm?	Y / N	
14.	Have you had a severe viral infection (for example, myocarditis or mononucleosis)?	Y / N	
15.	Has a physician ever denied or restricted your participation in sports for any heart problems?	Y / N	
16.	Do you have an current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters?	Y / N	
17.	Have you ever had a head injury or concussion?	Y / N	
18.	Have you ever been knocked out, become unconscious, or lost your memory?	Y / N	
	a. If yes, how many times? _____		
	b. When was the last concussion? _____		
	c. How severe was each one? (Explain in the space provided)		
	_____		
	_____		
	_____		
		Y / N	
19.	Have you ever had a seizure?	Y / N	
20.	Do you have frequent or severe headaches?	Y / N	
21.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Y / N	
22.	Have you ever had a stinger, burner, or pinched nerve?	Y / N	
23.	Have you ever become ill from exercising in the heat?	Y / N	
24.	Have you ever gotten unexpectedly short of breath with exercise?	Y / N	
25.	Do you cough, wheeze, or have trouble breathing during or after activity?	Y / N	
26.	Do you have asthma?	Y / N	
27.	Do you have seasonal allergies that require medical treatment?	Y / N	
28.	Have you had any problems with your eyes or vision?	Y / N	
29.	Are you missing any paired organs?	Y / N	
30.	Do you use any 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, or hearing aid)?	Y / N	
31.	Have you ever had a sprain, strain, or swelling after injury?	Y / N	
32.	Have you ever broken or fractured any bones or dislocated any joints?	Y / N	
33.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	Y / N	
	a. If yes, check the appropriate one and explain below		
	___ Head ___ Elbow ___ Hip ___ Neck ___ Knee		
	___ Chest ___ Thigh ___ Back ___ Wrist ___ Hand		
	___ Shoulder ___Finger ___ Ankle ___ Upper Arm		
	___ Shin/Calf ___ Foot ___Forearm		
34.	Do you want to weigh more or less than you do now?	Y / N	
35.	Do you lose weight regularly to meet requirements for your sport?	Y / N	
36.	Do you feel stressed out?	Y / N	
37.	Record the dates of your most recent immunization (Shots) or disease for:		
	Tetanus_____ Measles_____		
	Hepatitis B _____ Chickenpox _____		
38.	Are you currently under a doctor's care?	Y / N	

Explain "Yes" answers here:

_____
_____
_____

FOR FEMALES ONLY:

1.	When was your first menstrual period?	Y / N
2.	What was your most recent menstrual period?	Y / N
3.	How much time do you usually have from the start of one period to the start of another?	Y / N
4.	How many periods have you had in the last year?	Y / N
5.	What was the longest time between periods in the last year?	Y / N

Please list all prescribed medication taken by your child:

_____
_____
_____

STUDENT, PARENT, AND PHYSICIAN ALL MUST SIGN THIS FORM

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Signature: _____

I have reviewed and acknowledge the information in this Medical History Form

Physician's or Authorized Examiner's Signature: _____ Date: _____

FRASSATI CATHOLIC HIGH SCHOOL
PHYSICAL: EXAMINATION FORM

Student's Name:_____

Height:_____ Weight:_____ Pulse:_____ Blood Pressure:_____ % Body Fat (optional)_____
Vision R 20/_____ L 20/_____ Corrected: Yes____ No____ Pupils: Equal_____ Unequal_____
Hearing: Normal_____ Referred_____ Spinal Exam: Normal_____ Referred_____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine			
Heart-Auscultation of the heart in the standing position			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE
□ Cleared for Participation in Athletics
□ Not cleared for Participation Reason:_____

Recommendations and/or Restrictions:_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practiced Nurse by the Board of Nurse Examiners.

Name (print/type): _____Date of Examination:_____

Address:_____Phone Number: _____

Signature: _____Title:_____