

INTERCOLLEGIATE ATHLETICS
Athletic Health History Form



NAME _____ DATE OF BIRTH _____ TODAY'S DATE _____

PLEASE CIRCLE ALL ANSWERS EITHER **YES** OR **NO**. FOR ALL **YES** ANSWERS, PROVIDE EXPLANATIONS IN BOX

GENERAL ~ Do you now, or have you ever had.....

High blood pressure	YES NO	
Tuberculosis	YES NO	
Appendicitis	YES NO	
Hepatitis	YES NO	
Hernia	YES NO	
Abnormal bleeding tendencies	YES NO	
Diabetes	YES NO	
Respiratory problems (asthma, EIA, etc)	YES NO	
Epilepsy	YES NO	
Stomach problems	YES NO	
Kidney disease	YES NO	
Coughing or wheezing after exercise	YES NO	
Eczema	YES NO	
Heat Illness (cramps, stroke, exhaustion)	YES NO	
Rheumatic fever	YES NO	
FEMALES: Menstrual irregularities	YES NO	
Allergies	YES NO	Allergic to:
Any other serious illness not listed above	YES NO	

CARDIAC ~ Do you now, or have you ever.....

Had chest pain during exercise?	YES NO	
Passed out or fainted during exercise?	YES NO	
Been dizzy during exercise?	YES NO	
Been told you had a heart murmur?	YES NO	
Racing of your heart or skipped heartbeats?	YES NO	
Had anyone in your family die of a heart attack or sudden death before the age of 50?	YES NO	

HEAD & NECK ~ Do you now, or have you ever had.....

A concussion	YES NO	How many & when?
Knocked out or unconscious?	YES NO	How many times and when?
An eye injury or impairment?	YES NO	
A nose injury or impairment?	YES NO	
Frequent headaches?	YES NO	
A Neck injury?	YES NO	
A "burner", "stinger", or pinched nerve?	YES NO	
A throat injury	YES NO	
Surgery relating to any of the above	YES NO	
Other injury not listed above?	YES NO	

BACK & SPINE ~ Do you now, or have you ever had.....

A spinal injury?	YES NO	
Low back pain or impairment?	YES NO	
Other injuries relating to the back or spine	YES NO	
Surgery relating to any of the above?	YES NO	

SHOULDER ~ Do you now, or have you ever had.....

A dislocation?	YES NO	
A separation?	YES NO	
Tissue or muscle injury?	YES NO	
Nerve damage (burner or stinger)?	YES NO	
Other injury not listed above?	YES NO	
Surgery relating to any of the above?	YES NO	

ARM, WRIST & HAND ~ Do you now, or have you ever had.....

A broken arm or elbow	YES NO	
A broken wrist or hand	YES NO	
Broken fingers?	YES NO	
Tissue or muscle injury?	YES NO	
Other injuries not listed above?	YES NO	
Surgery relating to any of the above?	YES NO	

KNEES ~ Do you now, or have you ever had.....

A ligament injury?	YES NO	
A cartilage injury?	YES NO	
Muscle or tendon injuries?	YES NO	
Bone injuries?	YES NO	
Other injuries not listed above?	YES NO	
Arthroscopic surgery?	YES NO	
Other injuries not listed above?	YES NO	
Open surgery to the knees?	YES NO	

FEET & ANKLES ~ Do you now, or have you ever had.....

A broken ankle?	YES NO	
Stress fractures?	YES NO	
Shin splints?	YES NO	
Broken toes?	YES NO	
Chronic sprained ankles?	YES NO	
Arch problems?	YES NO	
Other injuries not listed above	YES NO	
Surgery relating to the ankles or feet?	YES NO	

MEDICATION ~ Are you taking.....

Any short-course medication?	YES NO	NAME OF MEDICATION(S)
Any permanent medication?	YES NO	NAME OF MEDICATION(S)
Any dietary supplements such as creatine or ripped fuel?	YES NO	NAME OF SUPPLEMENT(S)

I certify that all of the information provided above is accurate and true to the best of my knowledge.

SIGNATURE _____ **TODAY'S DATE** _____

INTERCOLLEGIATE ATHLETICS
Athletic Physical Exam Form



NAME _____ DATE OF BIRTH _____

SPORT(S) _____ TODAY'S DATE _____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ PULSE _____

INTERNAL EXAM

Skin _____ Abdomen _____

Nutrition _____ Hernia _____

HEENT _____ Genitourinary _____

Chest _____ Neurologic _____

Lungs _____ Emotional _____

Cardiac _____

DIAGNOSIS _____

RECOMMENDATIONS _____

PHYSICIAN'S SIGNATURE _____ ***DATE*** _____

ORTHOPEDIC EXAM

Neck _____ Hands _____

Back _____ Hips _____

Shoulders _____ Legs _____

Arms/Elbows _____ Ankles _____

Forearms/Wrists _____ Feet _____

Knees _____

DIAGNOSIS _____

RECOMMENDATIONS _____

PHYSICIAN'S SIGNATURE _____ ***DATE*** _____

INTERCOLLEGIATE ATHLETICS
Physician's Letter



To the Physician:

The following Physical Exam form must be completed for clearance to participate in intercollegiate athletics at St. Norbert College.

Please review the Health History form, complete both sections of the exam form, and use the spaces available on the form to make any diagnoses and recommendations regarding this athlete.

By signing this form, you are stating that this athlete may participate in intercollegiate athletics at St. Norbert College.

Name of Athlete: _____

Signature of Physician: _____

Print Physician's Name: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Area Code and Phone Number: _____

Date of Exam: _____

If you have any questions or special concerns regarding this athlete or this exam, please contact Russ Schmelzer, LAT or Ryan Vandervest, LAT in the St. Norbert College Athletic Training Room at 920-403-3179