

List any current medications (include over the counter and birth control pills, vitamins, supplements and inhalers)

List any allergies:

Date of last tetanus shot:

Have you ever had:	Y	N	Comments
Loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Concussion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions (seizures) or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
“Stinger”, “burner” or “pinched nerve”?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a neck injury of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, temporary or longstanding, type of injury.			_____
Have you ever had any back injury/pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, temporary or longstanding, location, dates.			_____
Any special x-rays?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you undergo rehabilitation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever sustained a shoulder injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, indicate type of injury, shoulder, and dates.			_____
R L			_____
Did you have surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If Yes, when? _____			_____
Did you undergo rehabilitation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever sustained a knee injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, indicate type of injury, knee and dates.			_____
R L			_____
Did you have surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If Yes, when? _____			_____
Did you undergo rehabilitation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever sprained your ankle?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, indicate type of injury, ankle and dates.			_____
R L			_____
Did you have surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If Yes, when? _____			_____
Did you undergo rehabilitation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever worn a special brace, or had modifications made in equipment worn?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If Yes, indicate reason, duration worn.			_____
Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If Yes, when, indicate location, and treatment.			_____
Have you ever been treated for a mental condition?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If Yes, specify when, where, and nature of condition.			_____
Do you have any other medical or physical condition not mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Explain.			_____
Females			_____
Have you had or do you now have menstrual irregularities or absence of menses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Longest time between periods in last year. _____			_____
Age at first period? _____			_____
Last menstrual period? _____			_____



I attest that the above information is correct and complete to my knowledge.

Signature _____ Date _____

Oklahoma Panhandle State University Sports Medicine

PHYSICAL EXAMINATION

(To be completed by physician)

Date _____ Name _____ Sport _____

Blood Pressure _____ Pulse _____ Height _____ Weight _____

Vision: R 20/ _____ L 20/ _____ Corrected Yes / No

	Nml	Abnml	Comments
HEENT	()	()	_____
Cardiac	()	()	_____
Lungs	()	()	_____
Skin	()	()	_____
Abdominal	()	()	_____
Genitalia	()	()	_____
Upper Extremity Joints	()	()	_____
Lower Extremity Joints	()	()	_____
Spine & Musculature	()	()	_____

Other: _____

I certify that I have reviewed the history and examined the above student and I recommend:

	Comments
_____ Clearance with no limitations.	_____
_____ Clearance pending further evaluation or testing. (Please explain)	_____
_____ Referral to other health care professional prior to clearance. (Please explain)	_____
_____ Clearance with limitations. (Please explain)	_____
_____ Disqualified from competition. (Please explain)	_____

Continue explanation on additional sheet if needed.

Name of Examining Physician _____

Address _____

Phone () _____

Physician's Stamp

Signature _____ Date _____