HEALTH SERVICES
Oakton Community College

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Athletic Physical

TO BE COMPLETED BY STUDENT (questions 1-16)

Name ______________________ Sport(s) ______________________

Social Security number ______________________ Date of Birth ______________________ Age ________

Address ______________________ City ______________________ State ____ Zip __________

Home Phone ______________________ Cell Phone ______________________

Emergency Contact ______________________ Relationship ______________________ Phone ______________

1. Have you ever had any of the following problems during or after exercising:

Chest pain/discomfort	❑ Yes	❑ No
Passing out	❑ Yes	❑ No
Severe lightheadedness/dizziness	❑ Yes	❑ No
Coughing	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No
Extreme shortness of breath	❑ Yes	❑ No
Excessive fatigue	❑ Yes	❑ No

2. Have you ever had any of the following injuries?

Concussion/knocked out	❑ Yes	❑ No
Neck pain/injury	❑ Yes	❑ No
Back pain/injury	❑ Yes	❑ No
Broken bone	❑ Yes	❑ No
Joint injury	❑ Yes	❑ No
Ligament/muscle injury	❑ Yes	❑ No
Sprains/strains	❑ Yes	❑ No
Stingers/Burners	❑ Yes	❑ No

If yes, how many?____ which arm?________

3. Has anyone in your family (including grandparents, aunts, uncles, cousins) ever died suddenly before age 50? ❑ Yes ❑ No

4. Has anyone in your family been diagnosed with:

Hypertrophic cardiomyopathy	❑ Yes	❑ No
Dilated cardiomyopathy	❑ Yes	❑ No
Long QT syndrome	❑ Yes	❑ No
Marfan syndrome	❑ Yes	❑ No
Arrhythmia	❑ Yes	❑ No

5. Do you worry about your weight?	❑ Yes	❑ No
6. Do you avoid eating meat?	❑ Yes	❑ No
7. Do you avoid eating dairy foods?	❑ Yes	❑ No
8. Do you smoke/chew tobacco?	❑ Yes	❑ No
9. Do you wear a seat belt?	❑ Yes	❑ No

10. Have you had medical problems such as:

Heart murmur	❑ Yes	❑ No
High blood pressure	❑ Yes	❑ No
Heat stroke/heat exhaustion	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Mononucleosis	❑ Yes	❑ No
Bleeding problems	❑ Yes	❑ No
Bruise easily	❑ Yes	❑ No
Eye problems	❑ Yes	❑ No
Absence of one kidney	❑ Yes	❑ No
Absence of one testicle	❑ Yes	❑ No
Hernia	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Bee sting allergy	❑ Yes	❑ No
Menstrual problems	❑ Yes	❑ No

Asthma/Exercise Induced Asthma ❑ Yes ❑ No

All "YES" answers, describe: ______________________

____

11. Allergies ______________________
______________________ ❑ None

12. List any medications you take regularly (including inhalers):
______________________ ❑ None

13. List any other chronic illness or medical problems:
______________________ ❑ None

14. List any hospitalizations you have had: ______________
______________________ ❑ None

15. Females - menstrual period frequency:
During competitive sports season, every ___________ days.
During off-season, every ___________ days.

16. I, ______________________, authorize Health Services at Oakton Community College to
(print name)
release this medical information to the Oakton Athletics staff and I verify that the above information is correct.

______________________ ______________
Student athlete's signature *Date*

TO BE COMPLETED BY PHYSICIAN

Examining Physician ______________________________ **Date of Exam** ____________

Exam: Ht. __________ Wt. __________ B/P __________ Regular cuff or large cuff (circle) Pulse __________

Wear Glasses or Contacts? ❑ Yes ❑ No Vision R ____/____, L ____/____, Both ____/____ Pupils R = < > L

		NL
Upper Extr:	______________________	________
ROM	______________________	________
Symmetry	______________________	________
Spine/neck	______________________	________
Scoliosis	______________________	________
Lower Extr:	______________________	________
Gait	______________________	________
Squat	______________________	________
Duck walk	______________________	________
ROM	______________________	________

		NL
Lungs	______________________	________
Skin	______________________	________
Abdomen	______________________	________
Testicles	______________________	________
Hernia	______________________	________

Heart ❑ supine ❑ standing

Murmur ❑ Yes ❑ No

If yes, is there change with standing? ______________________

____

Other ____

Femoral pulses palpable? ❑ Yes ❑ No

If there is a history of joint injury, perform exam and describe: ______________________________

____

____

Findings/Recommendations: ____

____

____

____

____

____

❑ **Preventative issues addressed (as appropriate):** ETOH, Smoking, Drugs (steroids), Supplements, Safer sex, Seat belts, Nutrition, Accidents, and Driving.

❑ **Females:** Regular Pap Smear and Breast exam discussed ❑ **Males:** Self-testicular exam reviewed.

CLEARANCE (check one):

❑ Cleared for Collision Sports ❑ Cleared for Contact Sports ❑ Cleared for Non-Contact Sports

❑ Not Cleared (explain) ____

____

______________________ ____________ ______________________

Physician's signature *Date* *Physician's stamp*