

WBU MEDICAL HISTORY FORM FOR NEW ATHLETES

This medical history form must be completed by each athlete in order for the athlete to participate in NAIA athletics. These questions are designed to determine if the athlete has developed any condition which would make it hazardous to participate in the athletic event.

NAME: _____ DATE: _____
SEX: FEMALE / MALE DATE OF BIRTH: _____ CLASSIFICATION: _____
SPORT(S): _____

EXPLAIN "YES" ANSWERS BELOW (use a separate sheet of paper if needed). ANY "YES" ANSWER REQUIRES ADDITIONAL EXAMINATION

1. Have you ever a medical illness or injury since your last check up or sports physical? Yes ___ No ___
2. Have you been hospitalized overnight in the past year? Yes ___ No ___
3. Have you had surgery in the past year? Yes ___ No ___
4. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler? Yes ___ No ___
5. Do you have any allergies to medicine, food, stinging insects or ice? Yes ___ No ___
6. Have you ever passed out during or after exercise? Yes ___ No ___
7. Have you ever been dizzy during or after exercise? Yes ___ No ___
8. Have you ever had chest pain during or after exercise? Yes ___ No ___
9. Do you get tired more than your friends do during exercise? Yes ___ No ___
10. Have you ever had racing of your heart or skipped heartbeats? Yes ___ No ___
11. Have you had high blood pressure or high cholesterol? Yes ___ No ___
12. Have you ever been told you have a heart murmur? Yes ___ No ___
13. Has any family member or relative died of heart problems or of a sudden, unexpected death before age 50? Yes ___ No ___
14. Has any family member been diagnosed with an enlarged heart, hypertrophic Cardiomyopathy, long QT syndrome, Marfan's syndrome or abnormal heart rhythm? Yes ___ No ___
15. Have you had a severe viral infection (myocarditis or mononucleosis) within the last month? Yes ___ No ___
16. Has a physician ever denied or restricted your participation in sports for any heart problem? Yes ___ No ___
17. Do you have any current skins problems (itching, rashes, acne, warts, fungus or blisters?) Yes ___ No ___
18. Have you ever had a head injury or concussion? Yes ___ No ___
19. Have you ever been knocked out, become unconscious or lost your memory? Yes ___ No ___
If "Yes", how many times? _____
When was the last concussion? _____
How severe was each one? _____
20. Have you ever had a seizure? Yes ___ No ___
21. Do you have frequent or severe headaches? Yes ___ No ___
22. Have you ever had numbness or tingling in your arms, hand, legs or feet? Yes ___ No ___
23. Have you ever had a stinger, burner or a pinched nerve? Yes ___ No ___
24. Have you ever become ill from exercising in the heat? Yes ___ No ___
25. Have you ever had an unexpected shortness of breath with exercise? Yes ___ No ___
26. Do you cough, wheeze or have trouble breathing during or after exercise? Yes ___ No ___
27. Do you have asthma? Yes ___ No ___
If "Yes", do you use an inhaler? Yes ___ No ___
28. Do you have seasonal allergies that require medical treatment? Yes ___ No ___
29. Have you had any problems with your eyes or vision? Yes ___ No ___
30. Are you missing any paired organs? Yes ___ No ___
31. Do you use any special 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 aids?) Yes ___ No ___
32. Have you ever had a sprain, strain or swelling after injury? Yes ___ No ___
33. Have you broken or fractured any bones or dislocated any joints? Yes ___ No ___

34. Have you had any other problems with pain or swelling muscles, tendons, bones or joints? Yes___ No___
If "Yes", check below and explain (use a separate sheet of paper if necessary):

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

35. Do you have any pain or swelling from the past 12 months that has not been examined by a doctor? Yes___ No___
If "Yes", please explain in as much detail as possible (use a separate sheet of paper if necessary):

36. Record the dates of your most recent immunizations for:

Tetanus_____ Measles_____ Hepatitis B_____
Chickenpox_____

37. Are you under a doctor's care? Yes___ No___

Females Only:

38. When was your first menstrual period? _____
39. When was your most recent menstrual period? _____
40. How much time do you usually have from the start of one period to the start of the next? _____
41. How many periods have you had in the last 12 months? _____
42. What was the longest time between periods in the last year? _____

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

Student Signature

Date

Printed Name

WBU PHYSICAL EXAMINATION FORM FOR NEW ATHLETES

Date of Examination: _____
 Name: _____ SSN: _____ DOB: _____
 Male / Female Classification: Fr. Soph. Jr. Sr. Sport(s): _____

Physical Examination

Height: _____ Weight: _____ Pulse: _____ BP: _____
 Vision: R 20/_____ L 20/_____ Corrected: Y / N _____ Pupils: Equal _____ Unequal _____

As a minimum requirement, this physical examination form must be completed prior to NAIA athletic participation. It must be completed if there are "Yes" answers to specific questions on the athlete's MEDICAL HISTORY FORM.

Medical	Normal	Abnormal Findings	Initials*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in supine position			
Heart-Auscultation of the heart in standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

Musculoskeletal

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

***Station-based examination only**

CLEARANCE _____ Cleared _____ Cleared after completing evaluation/rehabilitation for: _____

_____ Not Cleared for: _____ Reason: _____

RECOMMENDATIONS: _____

The following information must be 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 Practice Nurse by the board of Nurse Examiners.

Signature of Physician: _____ Date: _____