(The parent or guardian should fll out this form with assistance from the student-athlete)   Exam Date: _____

Name: _____

Home Address: _____

Phone: _____

Date of Birth: _____

Age: _____

Gender: _____

Grade: _____

School: _____

Sport(s): _____

Personal Physician: _____

Hospital Preference: _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

In case of emergency contact:

Name: _____

Relationship: _____

Phone (Home): _____

Phone (Work): _____

Phone (Cell): _____

Name: _____

Relationship: _____

Phone (Home): _____

Phone (Work): _____

Phone (Cell): _____

12) Have you ever had a stress fracture?

13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?

14) Do you regularly use a brace or assistive device?

15) Has a doctor told you that you have asthma or allergies?

16) Do you cough, wheeze or have difficulty breathing during or after exercise?

17) Is there anyone in your family who has asthma?

18) Have you ever used an inhaler or taken asthma medication?

19) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?

20) Have you had infectious mononucleosis (mono) within the last month?

21) Do you have any rashes, pressure sores or other skin problems?

22) Have you had a herpes skin infection?

23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?

24) Have you ever had a seizure?

25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?

26) While exercising in the heat, do you have severe muscle cramps or become ill?

27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?

28) Have you ever been tested for sickle cell trait?

29) Have you had any problems with your eyes or vision?

30) Do you wear glasses or contact lenses?

31) Do you wear protective eyewear, such as goggles or a face shield?

32) Are you happy with your weight?

33) Are you trying to gain or lose weight?

34) Has anyone recommended you change your weight or eating habits?

35) Do you limit or carefully control what you eat?

36) Do you have any concerns that you would like to discuss with a doctor?

Y   N

37) Have you ever had a menstrual period?

38) How old were you when you had your

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last two weeks, how often have you been bothered by any of the following problems? (circle responses)

	Not At All	Several Days	Over Half The Days	Nearly Every Day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
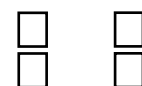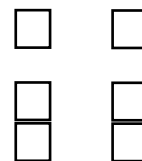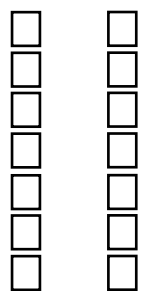
Name:_____ Date of Birth: _____

Age: _____ Sex: _____

Height: _____ Weight:_____

% Body Fat (optional): _____ Pulse: _____

BP: _____ / _____ (_____ / _____,_____ / _____)

Vision: R20/_____   L20/_____   Corrected: Y   N

Pupils: Equal   Unequal