

AVORS MEDICAL GROUP

Antelope Valley Orthopaedic & Rehabilitation Specialists

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Sports Physical Patient Forms Packet

- Medical Consent
- Patient Information
- Pre-Participation Evaluation Medical History
- Sports Physical Evaluation Results (to be completed by Dr. Smith)

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Medical Consent

Person Examined _____

Health Provider _____

This will acknowledge that I have been advised of the following:

1. That neither child's school nor Tony Smith, D.C. who will be performing my child's sports physical, intend that this examination will establish a health provider-patient relationship between my child, _____, and said health care provider. I, the child's parent/guardian, do not intend that Tony Smith, D.C. is not my child's doctor, he is a consultant to the _____ School District.
2. That this examination is not, and should not be treated as a substitute for a complete physical. The parent/guardian and child need to be aware that there are various conditions/diseases/illnesses that may be undetected in a screening exam or physical regardless of the extent of any examination.
3. That this examination is performed solely to advise the school district if my child is generally healthy enough at present to participate in athletics.
4. That my child's relationship with the above-named health provider is limited to this one-time examination and he does not intend to, nor do I expect that he will, treat my child or otherwise render professional services or advise as part of this screening or examination.
5. That the health provider charges a reasonable fee for pre-participation exams/physicals to benefit the athletes in our community. The fee paid at the time of exam is for the exam services only and is not contingent on the provider's assessment for participation.

Your signature below acknowledges that you have read and agree to the foregoing; and that you authorize and consent to the performance of the physical examination by the health provider.

Do not sign this Medical Consent without reading and understanding it. Thank you.

Date

Print Name of Athlete

Signature of Athlete

Print Name of Parent/Guardian

Signature of Parent/Guardian

Patient Information

Date of Exam _____

Name _____ Sex M F Date of Birth _____

Age _____ Grade _____ School _____

Personal Physician _____

In case of emergency, contact:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Pre-Participation Evaluation Medical History

Circle "Question Numbers" you do not know the answer to. Please explain "Yes" answers in blank lines at end of evaluation.

- | | | |
|-----|--|--|
| 1. | Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. | Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. | Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 4. | Do you have any allergies to medicine, pollens, foods, or stinging insects? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 5. | Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 6. | Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 7. | Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 8. | Does your heart race or skip beats during exercise? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 9. | Has your doctor ever told you that you have (check all that apply)?
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Infection | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 10. | Has a doctor ever ordered a test for your heart? (example: ECG or Echocardiogram) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 11. | Has anyone in your family died for no apparent reason? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 12. | Does anyone in your family have a heart problem? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 13. | Has anyone in your family died of heart problems or of a sudden death before the age of 50? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 14. | Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 15. | Have you ever spent the night in the hospital? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 16. | Have you ever had surgery? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Pre-Participation Evaluation Medical History (continued)

17. Have you ever had an injury, like a sprain, muscle tear, or tendinitis that caused you to miss a practice or a game? If yes, check below? No Yes
 Head Neck Shoulder Upper Arm Elbow Forearm
 Hand/Fingers Hip Thigh Knee Calf/Shin Ankle Foot/Toe
-
18. Have you ever had a broken or fractured bone or joint that required a brace, a cast or crutches? If yes, check below? No Yes
 Head Neck Shoulder Upper Arm Elbow Forearm
 Hand/Fingers Hip Thigh Knee Calf/Shin Ankle Foot/Toe
-
19. Have you ever had a bone or joint injury that required X-Ray, MRI, CT, Surgery, Injections, Rehabilitation, Physical Therapy, a brace, a case, or crutches? If yes, check below? No Yes
 Head Neck Shoulder Upper Arm Elbow Forearm
 Hand/Fingers Hip Thigh Knee Calf/Shin Ankle Foot/Toe
-
20. Have you ever had a stress fracture? No Yes
-
21. Have you been told that you have or have had an x-ray for an atlantoaxial (neck) instability? No Yes
-
22. Do you regularly use a brace or assistive device? No Yes
-
23. Has a doctor ever told you that you have asthma or allergies? No Yes
-
24. Do you have a cough, wheeze, or have difficulty breathing during or after exercise? No Yes
-
25. Is there anyone in your family who has asthma? No Yes
-
26. Have you ever used an inhaler or taken asthma medication? No Yes
-
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? No Yes
-
28. Have you had an infectious mononucleosis (mono) within the last month? No Yes
-
29. Do you have any rashes, pressure sores, or other skin problems? No Yes
-
30. Have you had herpes skin infections? No Yes
-
31. Have you ever had a head injury or concussion? No Yes
-
32. Have you ever been hit in the head and been confused or lost your memory? No Yes
-
33. Have you ever had a seizure? No Yes
-
34. Do you have headaches with exercise? No Yes
-
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? No Yes
-
36. Have you ever been unable to move your arms or legs after being hit or falling? No Yes
-
37. When exercising in the heat, do you have severe muscle cramps or become ill? No Yes
-
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? No Yes

Pre-Participation Evaluation Medical History (continued)

39. Have you had any problems with your eyes or vision? No Yes

40. Do you wear glasses or contact lenses? No Yes

41. Do you wear protective eyewear, such as goggles or a face ligament shield? No Yes

42. Are you happy with your weight? No Yes

43. Are you trying to gain or lose weight? No Yes

44. Has anyone recommended you change your weight? No Yes

45. Do you limit or carefully control what you eat? No Yes

46. Do you have any concerns that you would like to discuss with the doctor? No Yes

Females Only

47. Have you ever had a menstrual cycle? No Yes

48. How old were you when you had your first menstrual cycle? _____

49. How many periods have you had in the last 12 months? _____

Explain "Yes" answers here:

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

Signature of Athlete _____

Signature of Parent/Guardian _____

Date _____

**Sports Physical
Evaluation Results**
(to be completed by Dr. Smith)

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP _____ / _____ (_____ / _____, _____ / _____)

Vision R 20/ _____ L 20/ _____ Corrected No Yes Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

**Sports Physical
Evaluation Results** (continued)
(to be completed by Dr. Smith)

- Cleared without restriction.
- Cleared with recommendations for further evaluation or treatment for _____

Not cleared for: All Sports Certain Sports _____

Reason _____

Recommendations _____

Tony Smith, D.C.

Date