WORCESTER PUBLIC SCHOOLS
DEPARTMENT OF HEALTH, PHYSICAL EUCATION AND ATHLETICS
SPORTS CANDIDATE MEDICAL QUESTIONNAIRE

PART A – HISTORY

DATE OF EXAM _____

Student's Name		Sex	Age	Date of Birth
Grade	School		Sport(s)	
Address			Tel	
Physician			Tel	

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____ Tel (H) _____ (W) _____

EXPLAIN 'YES' ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

	YES	NO		YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?			21. Have you ever been knocked out, become unconscious, or lost your memory?		
2. Have you ever been hospitalized overnight?			22. Have you ever had a seizure?		
3. Have you ever had surgery?			23. Do you have frequent or severe headaches?		
4. Do you have a missing or diseased paired organ?			24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?			25. Have you ever had a stinger, burner, or pinched nerve?		
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?			26. Have you ever become ill from exercising in the heat?		
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?			27. Do you cough, wheeze, or have trouble breathing during or after activity?		
8. Have you ever had a rash or hives develop during or after exercise?			28. Do you have asthma?		
9. Have you ever passed out during or after exercise?			29. Do you have seasonal allergies that require medical		
10. Have you ever been dizzy during or after exercise?			30. 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, hearing aid)?		
11. Have you ever had chest pain during or after exercise?			31. Have you had any problems with your eyes or vision?		
12. Do you get tired more quickly than your friends do during exercise?			32. Do you wear glasses, contacts, or protective eyewear?		
13. Have you ever had racing of your heart or skipped heartbeat?			33. Have you ever had a sprain, strain, or swelling after injury?		
14. Have you had high blood pressure or high cholesterol?			34. Have you broken, or fractured any bones or dislocated any joints?		
15 Have you ever been told you have a heart murmur?			35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? *If yes, check appropriate box and explain below:* Head Neck Back Chest Shoulder Upper Arm Elbow Forearm Wrist Hand Finger Hip Thigh Knee Shin/Calf Ankle Foot		
16. Has any family member or relative died of heart problems or of sudden death before age 50?			36. Do you want to weight more or less than you do now?		
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?			37. Do you lose weight regularly to meet weight requirements for your sport?		
18. Has a physician ever denied or restricted your participation in sports for any heart problems?			38. Do you feel stressed out?		
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?			39. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chicken Pox _____		
20. Have you ever had a head injury or concussion?					

Continued -

FEMALES ONLY

40. When was your first menstrual period? _____
41. When was your most recent menstrual period? _____
42. How much time do you usually have from the start of one period to the start of another? _____
43. 43. How many periods have you had in the last year? _____
44. Was the longest time between periods in the last year? _____

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/Date _____ Signature of Parent-Guardian/Date _____

PART B – PHYSICAL EXAMINATION

DATE OF EXAM _____

STUDENT (Please print) _____ Date of Birth _____

Height _____ Weight _____ % of Body Fat (optional) _____ Pulse _____ BP ____/____ (____/____ , ____/____)

Eyes: R20/ _____ L20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
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***

Part C – CLEARANCE

Date of Exam _____

Cleared for athletics and physical education

Cleared after completing evaluation/rehabilitation for: _____

_____

Not cleared for: _____ Reason: _____

_____

Name of Physician (Please Print): _____ Signature of Physician: _____

Address: _____ Tel: _____