

Our Lady of Victory Catholic School Physical History Form

Name: _____ Grade: _____ Sport _____ Date: _____

****Parents: complete and present to the physician at time of physical examination**

DIRECTIONS: For each question circle "Y" for yes or "N" for no.

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| 1. Have you had a medical illness or injury since your last physical? | Y | N |
| 2. Have you ever had surgery? Describe _____ | Y | N |
| 3. Are you taking prescription or over the counter medications? Inhaler? | Y | N |
| 4. Do you have any allergies? List _____ | Y | N |
| 5. Has a physician ever denied your participation in sports for any reason? Describe _____ | Y | N |
| 6. Have you ever been dizzy or passed out during or after exercise? | Y | N |
| 7. Have you ever had chest pains during or after exercise? | Y | N |
| 8. Have you ever been told you have high blood pressure/high cholesterol? | Y | N |
| 9. Have you ever been told you have a heart murmur? | Y | N |
| 10. Have you ever had racing heart or skipped heartbeats? | Y | N |
| 11. Do you have skin problems (itching, rashes, warts, fungus, etc.)? | Y | N |
| 12. Have you ever developed a rash or hives after exercise? | Y | N |
| 13. Have you ever had a head injury/concussion? | Y | N |
| 14. Have you ever been knocked out or unconscious? | Y | N |
| 15. Have you ever had a seizure? | Y | N |
| 16. Have you ever had numbness, tingling in your arms, hands, legs or feet? | Y | N |
| 17. Have you ever had a stinger, burner or pinched nerve? | Y | N |
| 18. Have you ever had heat or muscle cramps? | Y | N |
| 19. Have you ever been dizzy or passed out from the heat? | Y | N |
| 20. Do you have asthma? | Y | N |
| 21. Do you cough, wheeze or have trouble breathing during or after activity? | Y | N |
| 22. Do you have any problems with your eyes or vision | Y | N |
| 23. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? | Y | N |
- If yes please circle all that apply.
Head Shoulder Thigh Neck Elbow Chest Forearm
Shin/Calf Back Wrist Ankle Hip Hand Foot
24. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.) the physician should be aware of? Please describe.

25. Dates of most recent immunizations: Tetanus _____
Measels _____ Hepatitis B _____ Chicken Pox _____

26. Females only: Date of first menstrual period _____
Last menstrual period _____
The longest time between periods last year (weeks) _____

To the best of my knowledge, the above information is complete and accurate.

Parent/Guardian Signature _____ Date: _____

(Copies: Principal, Coach)

(Revised: 6-4-04)