MEDICAL GROUP

Susan M. Nasser, D.O.

Sports Physical Patient Forms Packet

- ✓ Medical Consent
- ✓ Patient Information
- ✓ Pre-Participation Evaluation Medical History
- ✓ Sports Physical Evaluation Results

Family First Medical Group
42135 10th Street W., Suite 201
Lancaster, CA 93534
661-341-3800, Fax 661-341-3810

Medical Consent

Person Examined ____

Health Provider ____

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

1. That neither child's school nor **Family First** who will be performing my child's sports physical, intend that this examination will establish a heath provider-patient relationship between my child, ____________________________, and said health care provider. I, the child's parent/guardian, do not intend that **Family First** 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

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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?	❑ No ❑ Yes
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	❑ No ❑ Yes
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills?	❑ No ❑ Yes
4.	Do you have any allergies to medicine, pollens, foods, or stinging insects?	❑ No ❑ Yes
5.	Have you ever passed out or nearly passed out DURING exercise?	❑ No ❑ Yes
6.	Have you ever passed out or nearly passed out AFTER exercise?	❑ No ❑ Yes
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	❑ No ❑ Yes
8.	Does your heart race or skip beats during exercise?	❑ No ❑ Yes
9.	Has your doctor ever told you that you have (check all that apply)? ❑ High Blood Pressure ❑ Heart Murmur ❑ High Cholesterol ❑ Heart Infection	❑ No ❑ Yes
10.	Has a doctor ever ordered a test for your heart? (example: ECG or Echocardiogram)	❑ No ❑ Yes
11.	Has anyone in your family died for no apparent reason?	❑ No ❑ Yes
12.	Does anyone in your family have a heart problem?	❑ No ❑ Yes
13.	Has anyone in your family died of heart problems or of a sudden death before the age of 50?	❑ No ❑ Yes
14.	Does anyone in your family have Marfan syndrome?	❑ No ❑ Yes
15.	Have you ever spent the night in the hospital?	❑ No ❑ Yes
16.	Have you ever had surgery?	❑ No ❑ 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? ❑ Head ❑ Neck ❑ Shoulder ❑ Upper Arm ❑ Elbow ❑ Forearm ❑ Hand/Fingers ❑ Hip ❑ Thigh ❑ Knee ❑ Calf/Shin ❑ Ankle ❑ Foot/Toe	❑ No ❑ Yes
18.	Have you ever had a broken or fractured bone or joint that required a brace, a cast or crutches? If yes, check below? ❑ Head ❑ Neck ❑ Shoulder ❑ Upper Arm ❑ Elbow ❑ Forearm ❑ Hand/Fingers ❑ Hip ❑ Thigh ❑ Knee ❑ Calf/Shin ❑ Ankle ❑ Foot/Toe	❑ No ❑ Yes
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? ❑ Head ❑ Neck ❑ Shoulder ❑ Upper Arm ❑ Elbow ❑ Forearm ❑ Hand/Fingers ❑ Hip ❑ Thigh ❑ Knee ❑ Calf/Shin ❑ Ankle ❑ Foot/Toe	❑ No ❑ Yes
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 provider)

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 provider)

❑ Cleared without restriction.

❑ Cleared with recommendations for further evaluation or treatment for ________________________________

____

❑ Not cleared for: ❑ All Sports ❑ Certain Sports____

Reason ____

____

____

____

Recommendations ____

____

____

____

____
Provider

____
Date

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