Aquinas Catholic Schools
Sports Qualifying Physical Medical History Questionnaire

Student Name _____ Grade _____ Age _____

School _____ Type of Sport/Camp _____

History		Yes	No
1.	Have you ever fainted?	☐	☐
	During exercise?	☐	☐
	Have you had chest pain during exercise?	☐	☐
2.	Family history of sudden death?	☐	☐
	Before age 35?	☐	☐
	Before age 50?	☐	☐
	Cause: _____		
3.	Have you ever had a concussion, loss of consciousness, or head injury?	☐	☐
	If yes, how many? _____		
4.	Have you ever had heat stroke or heat exhaustion?	☐	☐
5.	Do you wheeze or cough during or after exercise?	☐	☐
	Do you have a history of asthma?	☐	☐
6.	Do you have any allergies? (medications, bee stings, pollens, food, etc.)	☐	☐
	If yes, please list _____		
7.	Any sports-related injuries since last exam?	☐	☐
	If yes, list injuries _____		
8	Have you been ill in the last month?	☐	☐
9.	Do you take any medications (including vitamins and nonprescription drugs?	☐	☐
10.	Have you ever been hospitalized?	☐	☐
	Have you ever had surgery?	☐	☐
	If yes, please explain _____		
	_____		
11.	If female, what is the date of your last menstrual period _____		
	Age at onset of first period _____		
12.	In the last year, what was your		
	Lowest weight _____Highest weight _____		
13.	Immunizations		
	Date of last tetanus vaccine_____		
	Date of last measles, mumps, rubella (MMR) vaccine_____		
14.	Circle any of the following you have had		

Abnormal bleeding/bruising	Anemia	Diabetes
Broken bone/stress fracture	Dislocation (shoulder, etc.)	Seizures
Hearing impairment	Heart murmur/palpitations	Scoliosis
Hepatitis/jaundice	High blood pressure	Loss of eyesight
Rheumatic fever	Sickle-cell disease	Undescended testicle
Single organ (kidney, eye, etc.)		

Other_____

Aquinas Catholic Schools
Athletic Medical Form

Name (Last, First)		Birthdate	
Parent Name	Address		
Home Phone No.	Emergency Phone No. (not home)		
Family Doctor	Hospital or Clinic		
School	Grade	Height	Weight

I understand that this is an athletic physical and does not replace a complete physical. I do not hold this physician responsible for any injury which may occur during my child's participation in athletic events.

_____
Parent Signature/Date

Physical Screening Report

Heart Rate	Hernias	Blood Pressure

Physician's comments:

_____ _____
Physician's Signature Date