JAMES R. MC CLURG, M.D., APC
<u>SPORTS PARTICIPATION PHYSICAL</u>

Patient Name: ____ Today's date: ____________________

DOB: __________ AGE: _______________ ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

Who referred you to this office? ____

School / sport: ____

<u>Past Medical History:</u>

Have you ever been diagnosed with any serious medical condition? ☐ **Yes** ☐ **No**

Explain: ____

Are you currently under active care for any medical condition? ☐ **Yes** ☐ **No**

Name and phone number of doctor: ____

Please list any operations (and dates) you have ever had: ___________________________

____

Have you been hospitalized within the last 10 years? ☐ Yes ☐ No Why? _______________

Please list any current medications: ____

List any allergies to foods or medications: ______________________________________

<u>Family History:</u> Please Check the "yes" or "no" box to indicate whether **<u>any relatives</u>** have any of the following illnesses. If yes, please indicate which relative(s) have the problem.

	Yes	No	
Tuberculosis	☐	☐	____________________
Cancer	☐	☐	____________________
Arthritis	☐	☐	____________________
Kidney problems	☐	☐	____________________
Asthma	☐	☐	____________________
Heart problems	☐	☐	____________________
Epilepsy	☐	☐	____________________
Ulcers	☐	☐	____________________
High blood pressure	☐	☐	____________________
Excessive bleeding	☐	☐	____________________
Diabetes	☐	☐	____________________
Hepatitis	☐	☐	____________________
Osteoporosis	☐	☐	____________________
Bleeding disorder	☐	☐	____________________
Anesthesia problems	☐	☐	____________________

Birth defects ☐ ☐ ______________________________
Depression ☐ ☐ ______________________________
Psychiatric disorder ☐ ☐ ______________________________

Social History:

Place of birth? ______________________________

Education completed? ______________________________

	Yes	**No**		
Do you smoke?	☐	☐	**How much?** ____________	**How long?** ____________
Do you drink?	☐	☐	**How much?** ____________	**How often?** ____________
Sports or exercise?	☐	☐	**Explain:** ____________	

ORTHOPEDIC HISTORY

Do you have any problems with exercise? ☐ **Yes** ☐ **No**

Explain: ______________________________

Have you participated in sports previously? ☐ **Yes** ☐ **No**

What sport & how long? ______________________________

Have you had any injuries or broken bones? ☐ **Yes** ☐ **No**

Explain: ______________________________

Do you have any joint or muscle pain? ☐ **Yes** ☐ **No**

Where is it? ______________________________

Do you have any problems with your back? ☐ **Yes** ☐ **No**

Explain: ______________________________

1. **Is there any stiffness?** ☐ **Yes** ☐ **No** **Where?** ____________
2. **Is there any weakness?** ☐ **Yes** ☐ **No** **Where?** ____________
3. **Is there any numbness?** ☐ **Yes** ☐ **No** **Where?** ____________
4. **Is there any tingling?** ☐ **Yes** ☐ **No** **Where?** ____________
5. **Any locking in joints?** ☐ **Yes** ☐ **No** **Where?** ____________
6. **Any popping of joints?** ☐ **Yes** ☐ **No** **Where?** ____________
7. **Any giving way of joints?** ☐ **Yes** ☐ **No** **Where?** ____________
8. **Any grinding of joints?** ☐ **Yes** ☐ **No** **Where?** ____________
9. **Is there any swelling of joints?** ☐ **Yes** ☐ **No** **Where?** ____________
10. **Any deformity of joints?** ☐ **Yes** ☐ **No** Where? ____________
11. **Any instability of joints?** ☐ **Yes** ☐ **No** Where? ____________

Review of Systems:

Please check the "Yes" or "No" box to indicate if you are experiencing any of the following symptoms:

		Yes	No		Yes	No
GENERAL:	Fevers	☐	☐	Chills	☐	☐
	Night sweats	☐	☐			
ENT:	Ringing of ears	☐	☐	Hearing loss	☐	☐
	Frequent colds	☐	☐	Nose bleeds	☐	☐
EYES:	Dry eyes	☐	☐	Eye itching	☐	☐
LUNGS:	Wheezing	☐	☐	Coughing blood	☐	☐
	Shortness of breath	☐	☐	Frequent cough	☐	☐
CARDIAC:	Chest pain	☐	☐	Wake short of breath	☐	☐
	Palpitations	☐	☐	Leg swelling	☐	☐
	Fainting	☐	☐	Dizziness	☐	☐
GASTRO:	Heartburn	☐	☐	Trouble swallowing	☐	☐
	Vomiting blood	☐	☐	Rectal bleeding	☐	☐
	Jaundice	☐	☐	Black or tarry stools	☐	☐
SKIN:	Skin ulcers	☐	☐	Rashes	☐	☐
	Redness	☐	☐	Boils	☐	☐
NEURO:	Fainting	☐	☐	Balance problems	☐	☐
	Seizures	☐	☐	Loss of coordination	☐	☐
GU:	Blood in urine	☐	☐	Painful urination	☐	☐
	Dribbling	☐	☐	Delayed urination	☐	☐
	Kidney stones	☐	☐	Urinating at night	☐	☐
ENDO:	Excessive thirst	☐	☐	Excessive urination	☐	☐
	Tired /sluggish	☐	☐	Too cold or too hot	☐	☐
	Weight gain	☐	☐	Weight loss	☐	☐
HEMA:	Bleeding problems	☐	☐	Easy bruising	☐	☐
	Swollen glands	☐	☐	Blood clotting prob.	☐	☐
PSYCH:	Depression	☐	☐	High stress levels	☐	☐
	Eating disorder	☐	☐	Anxiety	☐	☐
ALLERGY:	Jewelry stains	☐	☐	Metal intolerance	☐	☐

Patient's signature: ____ Date: ________________________

Authorizing signature: ____ Relationship: ______________________