american family care URGENT CARE

5700 New Abbey Lane Suite D300
Castle Rock, CO 80108
Phone: 303-660-9700
Fax: 720-961-1940

Name:_____ Sports:_____ Date:_____

Age:_____ Date of Birth:___/___/_____ Home Phone:_____ School: _____

Parent or Student completes this section:

(Explain "Yes" Answers Below)

1. Have you ever been hospitalized?	Yes__ No__
2. Have you ever had surgery?	Yes__ No__
3. Are you currently taking any medications, pills, or supplements?	Yes__ No__
4. Have you ever passed out during or after exercise?	Yes__ No__
5. Have you ever been dizzy during or after exercise?	Yes__ No__
6. Have you ever had chest pain during or after exercise?	Yes__ No__
7. Do you tire more quickly than your friends during exercise?	Yes__ No__
8. Have you ever had high blood pressure?	Yes__ No__
9. Have you ever been told that you have a heart murmur?	Yes__ No__
10. Have you ever had racing of your heart or skipped heartbeats?	Yes__ No__
11. Have anyone in your family died of heart problems or a sudden death before age 50?	Yes__ No__
12. Have you ever had a head injury	Yes__ No__
13. Have you ever been knocked out or unconscious?	Yes__ No__
14. Have you ever had a seizure?	Yes__ No__
15. Have you ever had a stinger, burner, or pinched nerve?	Yes__ No__
16. Have you ever had heat or muscle cramps?	Yes__ No__
17. Have you ever been dizzy or passed out in the heat?	Yes__ No__
18. Do you have trouble breathing or do you cough during or after activity?	Yes__ No__
19. Do you have asthma?	Yes__ No__
20. Do you have any special equipment (pads, braces, guards, etc)?	Yes__ No__
21. Have you ever sprained/ strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones or joints?	Yes__ No__
22. If "yes" (question 21) at what location? (circle all that apply) Head Shoulder Thigh Neck Elbow Chest Foot Forearm Shin/Calf Back Wrist Ankle Hand	
23. Have you had any other medical problems?	Yes__ No__
24. Have you had a medical problem or injury since your last evaluation?	Yes__ No__
25. Have you ever smoked tobacco, used alcohol, or used any drugs?	Yes__ No__
26. For Women only: When was your first menstrual period? _____ When was your last menstrual period? _____ What was the longest time between your periods last year? _____	

Explanation of "Yes" answers: _____

_____

_____

Notice to Patients/ Parents

Because Doctors Express has limited access to your complete medical history, the sports physical performed today should not be considered comprehensive. You should consult with your primary care physician and share the results of our examination with them. If there are any concerns regarding the results of your examination today, you should consult with your primary care physician before engaging in any strenuous activities.

I hereby state that the above answers, to the best of my knowledge, are complete and correct.

Athlete Signature:_____ Date:____/____/_____

Parent/Gaurdian Signature:_____ Date:____/____/_____

For Office Use Only:

Height :_____ Weight_____ B/P:_____ /_____ Resting Pulse___

Vision: R 20/____ L 20/____ Corrected? Y___ N___ Hearing: Whisper Test Pass/Fail

Area	Normal	Abnormal	Area	Normal	Abnormal
HEENT			Neck		
Heart			Lungs		
Abdomen			Groin/ Hernia		
Extremities			Spine		
Neuro					

Clearance: A. Cleared for all Sports
B. Cleared only after Evaluation/ Rehabilitation for _____
C. Not cleared for:
__Collision __Contact __Noncontact __Strenuous __Moderately Strenuous

Due to: _____
_____

Comments: _____
_____

Signature of Practitioner: _____Date of Exam:___/____/_____

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