BEST CHOICE MEDICAL CLINIC

6391 HWY 72 – BYHALIA, MS 38611
PHONE 901-827-1853
KAREN BOLDEN, FNP-C

SCHOOL:_____ **School Year: 20**_____

PRE-PARTICIPATION MEDICAL HISTORY and PHYSICAL SCREENING FORM

Full Name:_____ Gender: M F Date of Birth:___/___/___ Age:_____

Sports:_____ Name of Family Physician:_____

MEDICAL HISTORY Circle "YES ", "NO" or "Don't Know" for each Question

Yes	No	Don't Know	1. Have you ever become dizzy, passed out or fainted during or after an activity?
Yes	No	Don't Know	2. Have you ever been told you have a heart murmur or other heart-related problems?
Yes	No	Don't Know	3. Does anyone in your immediate family have a heart-related condition or heart problems?
Yes	No	Don't Know	4. Has anyone in your family died suddenly (due to an illness or medical condition) before age 50?
Yes	No	Don't Know	5. Have you ever had a concussion, head injury, neck injury; or been knocked unconscious?
Yes	No	Don't Know	6. Have you ever suffered a seizure or been diagnosed as having Epilepsy?
Yes	No	Don't Know	7. Do you have any illnesses or conditions that require you to see a physician on a regular basis?
Yes	No	Don't Know	8. Have you ever been treated for medical conditions such as: Meningitis, Hepatitis, HIV/AIDS, Mononucleosis, Diabetes, Hemophilia, Cancer, Scoliosis of the Spine, Sickle Cell or Asthma?
Yes	No	Don't Know	9. Have you ever suffered from a heat–related illness? (Heat Exhaustion or Heat Stroke)
Yes	No	Don't Know	10. Are you missing a major body organ? (eye, ear, lung, kidney, spleen, testicle, ovary, etc.)
Yes	No	Don't Know	11. Have you ever been advised by a medical doctor NOT to participate in athletic-related activities?
Yes	No	Don't Know	12. Have you been hospitalized for any reason in the past year?
Yes	No	Don't Know	13. Do you take any medications on a regular basis for a medical condition?

List any FOOD or Medication Allergies:_____

Please provide information on any "Yes" answer to the above Questions:	

****DO NOT WRITE BELOW THIS BOX** **DO NOT WRITE BELOW THIS BOX** **DO NOT WRITE BELOW THIS BOX****

Height:____ft:/____in. Weight: _____lbs. Blood Pressure: _____/_____ Pulse:_____bpm

GENERAL	NORMAL	ABNORMAL	COMMENTS
Ear, Nose &Throat	☐	☐	
Chest, HeartLung & Abdomen	☐	☐	

MUSCULOSKELETAL	NORMAL	ABNORMAL	COMMENTS
Cervical Neck & Spine	☐	☐	
Upper Extremities	☐	☐	
Lower Extremities	☐	☐	
General Flexibility	☐	☐	

PHYSICIAN RECOMMENDATION FROM THIS LIMITED SCREENING: **PHYSICIAN SIGNATURE**

☐ CLEARED – NO RESTRICTIONS

☐ CLEARED -- After evaluation/rehabilitation for: _____ _____

☐ NOT CLEARED – Reason/Recommendation:_____ **EXAM DATE:** ___/___/_____

This Pre-Participation Medical History and Physical Screening does not take the place of a comprehensive physical examination which should be performed by you family physician. ****CONFIDENTIAL INFORMATION**** ****CONFIDENTIAL INFORMATION**** ****CONFIDENTIAL INFORMATION****