

Adolescent Sports Physical

LONG VERSION

IMPRINT AREA



KAISER PERMANENTE

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DATE _____



SPORTS PARTICIPATION QUESTIONNAIRE

Please explain "Yes" answers below. Circle questions you don't know the answers to. Thanks!

Do you have any **QUESTIONS** or **CONCERNS** that you would like to discuss today? None

Clinician Use Area

SPORTS QUESTIONS...

	Yes	No
1. Have you had a serious medical illness or injury since your last check up?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized or had any surgery since your last check up?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or "over the counter" medications?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies to medications?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any missing organs (eye, kidney, testicle)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any heart problems or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had chest pain or passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has any family member died suddenly at less than 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had convulsions (seizures)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a serious head injury, concussion or been knocked out?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you frequently cough or wheeze during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a serious joint injury or fracture?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you use any protective or corrective equipment (ex: knee brace)?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have any problems with pain or swelling of joints, bones or muscles?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have any current skin problem like fungus (ringworm)?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever been told not to participate in sports?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain "Yes" answers here:

FOR WOMEN...

20. At what age did you have your first menstrual period? _____ years old
21. When was your most recent menstrual period? _____ month/year
22. What was the longest time between periods in the last year? _____ months

Sign Here 1 _____

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

Signature of athlete _____

Signature of parent _____

STOP HERE. THANKS FOR FILLING OUT THIS QUESTIONNAIRE!

Adolescent Sports Physical

Speed Charting Plus V. 2.1



Age: _____ years Vision: R ___ / ___ L ___ / ___

Weight: _____ # Height: _____ in Blood Pressure: _____ / _____

Heart Rate: _____ Sign Here 1 _____ MA/LVN/RN

This information is **CONFIDENTIAL**. It will not be shared with **anyone** (unless you are considering suicide, or are being sexually or physically abused). Check "Skip It" if you prefer not to answer right now.

Clinician Use Area

C: Counseling

CONFIDENTIAL HEALTH QUESTIONS...

	Yes	No	Skip It
23. Are you having trouble in school (teachers, classes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you spend a lot of time thinking about food, weight and body size?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have serious concerns about being physically or sexually abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you smoked cigarettes or chewed tobacco in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you drunk alcohol (beer, wine, liquor) in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever tried other drugs (marijuana, cocaine, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you ever used sports performance enhancing drugs (steroids, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you ever been in a car where the driver was drinking or on drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you started having sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you ever seriously thought about killing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 _____

(C)

(C)

(C)

(C)

(C)

(C)

(C)

(C)

(C)

(C)

See Questionnaires

= YES, ORDERED
 = NO, NOT EXAMINED or ORDERED

HISTORY

PHYSICAL EXAM

NL	(NL = Normal, AB = Abnormal)	AB
<input type="checkbox"/>	Eyes (pupils equal).....	<input type="checkbox"/>
<input type="checkbox"/>	ENT (TM's clear, pharynx nl, no caries).....	<input type="checkbox"/>
<input type="checkbox"/>	Neck (supple, no adenopathy).....	<input type="checkbox"/>
<input type="checkbox"/>	Heart (regular rhythm, no murmur/gallop).....	<input type="checkbox"/>
<input type="checkbox"/>	Chest (clear, no rales or wheezing).....	<input type="checkbox"/>
<input type="checkbox"/>	Abdomen (no masses or organomegaly).....	<input type="checkbox"/>
<input type="checkbox"/>	Skin (no rashes).....	<input type="checkbox"/>
<input type="checkbox"/>	Genitalia-male (no hernia).....	<input type="checkbox"/>
	TANNER STAGE (male): 1 2 3 4 5	
<input type="checkbox"/>	Neurologic (non focal, nl tone).....	<input type="checkbox"/>

Abnormal Findings:

NL	Musculoskeletal	AB
<input type="checkbox"/>	symmetric extremities and trunk.....	<input type="checkbox"/>
<input type="checkbox"/>	normal ROM of neck.....	<input type="checkbox"/>
<input type="checkbox"/>	symmetric trapezius strength.....	<input type="checkbox"/>
<input type="checkbox"/>	symmetric deltoid size/strength, no pain.....	<input type="checkbox"/>
<input type="checkbox"/>	normal ROM of shoulders without pain.....	<input type="checkbox"/>
<input type="checkbox"/>	normal ROM of elbows.....	<input type="checkbox"/>
<input type="checkbox"/>	normal ROM of forearm & wrists.....	<input type="checkbox"/>
<input type="checkbox"/>	normal hand & fingers.....	<input type="checkbox"/>
<input type="checkbox"/>	normal ROM of back (no pain), no scoliosis.....	<input type="checkbox"/>
<input type="checkbox"/>	symmetric shoulders, waist, thighs and calves..	<input type="checkbox"/>
<input type="checkbox"/>	normal ROM without pain of knees & hips.....	<input type="checkbox"/>

ASSESSMENT

- Full Participation in All Sports Activities
- Limited Participation in:
- No Participation in:

PLAN

- Referral:** Teen Clinic P.T. Ob-Gyn Cardiology Orthopedics M. H.
- Immunizations:** Hep B Td MMR V-Z
- Labs:** CXR ECG V-Z Serology

R.T.C. in 1 and 6 months for Hep B vaccine
R.T.C. 1-3 Years for next Well Check or P.R.N.

Sign Here 1 _____

MD/DO/NP