KAS ATHLETE MEDICAL EXAMINATION FORM

(To be completed by the athlete or parent/guardian)

Note: Complete and sign this form (with your parents if younger than 18) before your admission.

Name:____Date of birth: _____________________
Date of examination:__________________________Sport (s):__________________________________
Gender (F, M or Others):__________________

Past and current medical conditions: ____
Have you ever had surgery? If yes, list all past surgeries: _____________________________________

Do you have any Chronic illness? If yes, list all: ____

List current medicines and supplements the athlete is using *(prescriptions, over-the-counter, and herbal or nutritional supplements)*:
____
____

Do you have any allergies? If yes, please list all:

Circle Question Number (1.) of questions for which the answer is unknown. Circle Y for Yes or N for No

GENERAL QUESTIONS

1.Do you have any concerns that you would like to discuss with the healthcare provider?....................Y / N
2. Has a healthcare provider ever denied or restricted your participation in sports for any reason?....................Y / N
3. Do you have any ongoing medical issues or recent illness?....................Y / N

HEART HEALTH QUESTIONS ABOUT YOU

4. Have you ever fainted or nearly fainted during or after exercise?....................Y / N
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?....................Y / N
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?....................Y / N
7. Has a doctor ever told you that you have any heart problems?....................Y / N
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography....................Y / N
9. Do you get light-headed or feel short of breath compared to your friends during exercise?....................Y / N
10. Have you ever had a seizure?....................Y / N

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?....................Y / N
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?....................Y / N
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?....................Y / N

BONE AND JOINT QUESTIONS

14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?....................Y / N
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?....................Y / N

MEDICAL QUESTIONS

16. Do you cough, wheeze, or have difficulty breathing during or after exercise?....................Y / N
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?....................Y / N
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?....................Y / N
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? Y / N
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?....................Y / N
21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?....................Y / N
22. Have you ever become ill while exercising in the heat?....................Y / N
23. Do you or does someone in your family have sickle cell trait or disease?....................Y / N
24. Have you ever had, or do you have any problems with your eyes or vision?....................Y / N
25. Do you worry about your weight?....................Y / N
26. Are you trying to or has anyone recommended that you gain or lose weight?....................Y / N
27. Are you on a special diet or do you avoid certain types of foods or food groups?....................Y / N
28. Have you ever had an eating disorder?....................Y / N

FEMALES ONLY

29. Have you ever had a menstrual period?.. Y / N
30. How old were you when you had your first menstrual period? _____
31. When was your most recent menstrual period? ____________
32. How many periods have you had in the past 12 months? ________

Height _ ______________ Weight _ ________________ BMI (optional) _ _____________________ % Body fat (optional) _ __________________________ Arm Span ________

Pulse _ __________________ BP_________/_________

Vision: R 20/____L 20/_____Corrected: Y / N Contact_______ Hearing: R____L_____(Audiogram or confrontation)
Colour Blindness: Y/N

Exam	Normal	Abnormal Findings	Initials*
Appearance			
Circle any Marfan stigmata present	→	Kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency	
HEENT			
Eyes			
Fundoscopic			
Pupils			
Hearing			
Cardiovascular[a]			
Describe any murmurs present (standing, supine, +/- Valsalva)	→		
Pulses (simultaneous femoral & radial)			
Lungs			
Abdomen			
Tanner Staging (optional)	Circle	I II III IV V	
Skin (No HSV, MRSA, Tinea corporis)			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			
Functional (Double-leg squat test, single-leg squat test, and box drop or step drop test)			

[a]Consider ECG, echo-cardiogram, and/or referral to cardiology for abnormal cardiac history or examination findings

* For Multiple Examiners

Additional Notes: ____

Health Maintenance: Lifestyle, health, immunizations, & safety counseling Discussed dental care & mouthguard use.
☐ Discussed Lead and TB exposure – (Testing indicated / not indicated) ☐ Eye Refraction if indicated

Provider Signature:____ Date: _________________

ATHLETE WITH DISABILITIES SUPPLEMENT TO THE ATHLETE HISTORY

Name:____Date of birth: ______

1. Type of disability:
2. Date of disability:
3. Classification (if available):
4. Cause of disability (birth, disease, injury, or other):
   If other, specify: _______________
5. List the sports you are playing:

6. Do you regularly use any assistive device for daily activities? specify: _________ Y / N
7. Do you use any assistive technology for sports? Y / N
8. Do you have any rashes, pressure sores, or other skin problems? Y / N
9. Do you have a hearing loss? Y / N
10. Do you use a hearing aid? Y/N
10. Do you have a visual impairment? Y / N
11. Do you use any special devices for bowel or bladder function? Y / N
12. Do you have burning or discomfort when urinating? Y / N
13. Have you had autonomic dysreflexia? Y / N
14. Have you ever been diagnosed as having a heat-related or cold-related illness? Y / N
15. Do you have muscle spasticity? Y / N
16. Do you have frequent seizures that cannot be controlled by medication? Y / N

Explain "Yes" answers here.

Please indicate whether you have ever had any of the following conditions:

Atlantoaxial instability	Y / N
Radiographic (x-ray) evaluation for atlantoaxial instability	Y / N
Dislocated joints (more than one)	Y / N
Easy bleeding	Y / N
Enlarged spleen	Y / N
Hepatitis	Y / N
Osteopenia or osteoporosis	Y / N
Difficulty controlling bowel	Y / N
Difficulty controlling bladder	Y / N
Numbness or tingling in arms or hands	Y / N
Numbness or tingling in legs or feet	Y / N
Weakness in arms or hands	Y / N
Weakness in legs or feet	Y / N
Recent change in coordination	Y / N
Recent change in ability to walk	Y / N
Spina bifida	Y / N
Latex allergy	Y / N

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete/Guardian:________________________Signature of parent or guardian: _ Date:/_________/___________________

Additional Examiner Notes/Restrictions:

This is to certify that (name of athlete): ……………………………………………. was examined by me, and the information given is true to the best of my knowledge.

Examiner E-mail: ____________________________________

Examiner Phone: ____________________________________

License: ____

Examiner's Signature and rubber stamp

Date (dd/mm/yyyy)