Sport: _____ **Date of Examination**:_____

NORTH IDAHO COLLEGE INITIAL SPORTS SCREENING EXAMINATION

To help us meet your health care needs please fill out this form to the best of your ability. This is a confidential record of your medical history and will be kept in Student Health Services.

PLEASE PRINT LEGIBILY

Last Name First Middle Maiden

Local Address City State Zip code

Current Phone Number Age Date of Birth e-mail address

Name of Primary Health Care Provider and Phone Number Insurance Coverage

Social Security Number Student ID Number

In case of an emergency notify:

Name Address City State Phone Relationship

Have you been hospitalized or had surgery? Yes No
If yes, explain and give dates_____

Have you ever been unconscious, knocked out, had a concussion or fainted? Yes No
If yes, explain:_____

Have you ever had problems with fatigue, exhaustion, or heat stroke? Yes No
If yes, explain:_____

Do you have to stop when running a ½ mile (twice around track)? Yes No
Do you have chest pain with exercise? Yes No
Has anyone in your family under 50 years of age had a sudden death or died from heart problems? Explain_____

Do you drink alcohol? Yes No
If yes, how much and how often? _____

Do you smoke or chew tobacco? Yes No
If yes, how much each day? _____

Do you ever use street drugs? Yes No
If yes, what do you use?_____
How much and how often? _____

Do you ever not eat, vomit, use diet pills and/or laxatives to lose weight? Yes No

Have you ever been physically abused ie. hit, slapped, or kicked by someone? Yes No

Has anyone ever forced you to have sexual activities? Yes No

Does anyone in your household have a problem with drugs or alcohol? Yes No

Females only:
Date of last menstrual period:_____Regular_____Irregular_____

Do you take any medications regularly:

___No ___Aspirin/Tylenol ___ Ibuprofen
___Antibiotics ___Antidepressants ___Tranquilizers
___Laxatives ___Sleeping Pills ___Birth Control Pills
___Vitamins ___Herbs ___Other _____

Do you have an allergy to any medications:

___No Known Allergy ___Penicillin ___Sulfa ___Codeine
___Tetracycline ___Other_____

Have you ever had any problems with:

___Anemia ___Bleeding Disorders ___Ears(Hearing)
___Eyes ___Hernias ___Mono/Hepatitis
___Seizures ___Testicles ___Ulcers

Do you have any serious or chronic medical problems?

___None ___High Blood Pressure ___Heart Disease
___Asthma ___Kidney Disease ___Liver Disease
___Diabetes ___Nervous System ___Mental Health
___Thyroid ___Heart Murmur ___Heart Palpitations
Other, describe _____

Do you have a family history (siblings, mother, father, or grandparents) of any of the following:

Yes	*Who*	*Disease*
_____	_____	Cancer
_____	_____	Diabetes
_____	_____	Heart Trouble
_____	_____	High Blood Pressure
_____	_____	Drug or Alcohol Problem
_____	_____	Depression
_____	_____	Mental Health Problems

Have you ever had:

___Fractures or broken bones ___Shin Splints ___Dislocation
___Osgood-Schalatter's ___Stress Fracture ___Jumper's Knee
___Torn Ligament's ___Chondromalacia
Any other injuries that caused you to miss a game or practice, describe:

This information is current and true to the best of my ability.

Signed:_____

Revised 4/05

To Be Completed By Health Care Provider

Student's Name _____ Date of Birth _____

Objective: Height _____ Weight _____ Blood Pressure _____ Pulse Resting _____ Pulse - 2 minutes exercise _____

System	N = Normal and AB = Abnormal	N	AB	Comments
Head	Hair, Scalp, and Masses			
Eyes	Lids, Conjunctiva, Sclera, and Pupils			
Ears	Gross Hearing to Speech, and TM=s			
Nose	Septum and Mucosa			
Mouth / Throat	Infections, Lesions, Teeth, Tongue, and Tonsils			
Neck	Adenopathy, Range of Motion, and Thyroid			
Thorax / Lungs	Deformities and Auscultation			
Heart	Gallops, Murmurs, and Sounds			
Abdomen	Tenderness,Organomegaly and/or Masses			
Genitalia	Lesions, Discharge, Scrotum, Testicles, and Hernias			
Upper & Lower Extremities	Joints, Motion, Limitation, Pulses, Muscle flexibility, and Deformities			
Back	Flexion, Extension, Scholiosis, Kyphosis, and Excessive Lordosis			
Neurological	Reflexes, Motor, and Gait			
Skin	Lesions			
Mental Status	Affect			

Disposition:

_____ 1) Unrestricted activity in all sports except:_____

_____ 2) No participation until ____/___/____; and/or:_____

_____ 3) Conditional participation, limited to:_____

_____ 4) No participation in any sport, or specific sports:_____

_____ _____

Date Health Care Provider Signature Phone

_____

Printed Name of Health Care Provider

North Idaho College, Student Health Services, 1000 West Garden Avenue, Coeur d=Alene, Idaho 83814
Phone Number: 208.769.7818 Fax Number: 208.665.5438