Baton Rouge Soccer Club
Sports Medicine
Medical History/Pre-participation Exam Form

Print clearly and fill out the following questionnaire to the best of your knowledge

ATHLETE INFORMATION			
Athlete's Name (last, first, middle)		Date of Birth	Gender
Today's Date		Team	
Address	City	State	Zip Code
Home Phone Number		Email Address	
IN CASE OF EMERGENCY			
Name	Relationship	Home Phone	Mobile Phone

FAMILY MEDICAL HISTORY *For each FULL-BLOODED relative listed, indicate if they have a history of the following (DO NOT include adoptive, step, or foster relatives). If YES, specify relationship.*			
			Relationship
High Blood Pressure	Yes □	No □	
Family member died of a heart related problem before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)	Yes □	No □	
Family member suffered a disability related to heart disease before the age of 50	Yes □	No □	
Pacemaker or Implanted Defibrillator	Yes □	No □	
High blood Cholesterol	Yes □	No □	
Other Heart Problems	Yes □	No □	
Unexplained fainting, unexplained seizures, or near drowning	Yes □	No □	
Asthma	Yes □	No □	
Stroke	Yes □	No □	
Kidney disease	Yes □	No □	
Diabetes	Yes □	No □	
Hemophilia/blood clotting disorder	Yes □	No □	
Family member with a heart condition (e.g. Marfan's Syndrome, Hypertrophic Cardiomyopathy, arryhthmogenic right ventricular cardiomyopathy, long QT/short QT syndrome, Brugada syndrome, or Catecholaminergic polymorphic ventricular tachycardia, etc.)	Yes □	No □	
Sickle Cell Trait/disorder	Yes □	No □	
Tuberculosis	Yes □	No □	
Gout	Yes □	No □	
Cancer	Yes □	No □	
Epilepsy	Yes □	No □	
Mental Illness	Yes □	No □	
Drugs and/or alcohol dependency	Yes □	No □	
Arthritis	Yes □	No □	
Additional family medical issues	Yes □	No □	

GENERAL MEDICAL INFORMATION *Indicate if you have allergies to the following:*			
Foods	Yes □	No □	Specify:
Insect or animals	Yes □	No □	Specify:
Latex, iodine, tape, or other allergies	Yes □	No □	Specify:
Over-the-counter and/or prescription medication	Yes □	No □	Specify:
Plants, grasses, pollens, dust, or environmental factors	Yes □	No □	Specify:
Other	Yes □	No □	Specify:
Are you prescribed an Epi-Pen and/or inhaler?	Yes □	No □	

Are you presently taking any prescribed or over-the-counter medications? (Include birth control, insulin, allergy shots/pills, asthma inhalers, anti-depressants, anti-inflammatory medications, and ADD/ADHD medications)

Name	Dose(strength)	How many times daily and/or weekly	Reason

MEN'S MEDICAL HISTORY		
Do you feel pain or burning with urination?	Yes □ No □	If yes, explain:
Any blood in your urine?	Yes □ No □	If yes, explain:
Has the force of your urine decreased:	Yes □ No □	If yes, explain:
Have you had kidney, bladder, or prostate infections in the last 12 months?	Yes □ No □	If yes, explain:
Do you have problems emptying your bladder totally?	Yes □ No □	If yes, explain:
Any testicular torsion, pain, or swelling?	Yes □ No □	If yes, explain:

WOMEN'S MEDICAL HISTORY		
Have you ever had a menstrual period?	Yes □ No □	
At what age did your menstrual cycle start?	Date:	Any problems?
When was your most recent menstrual cycle?	Date:	Any problems?
On an average how long has each period lasted?	Days:	Week:
How many periods have you had in the past 12 months?	Amount:	
Are you currently taking any female hormones such as estrogen, progesterone, birth control for regulating your period?	Yes □ No □	If yes, explain:
Trouble with heavy menstrual bleeding?	Yes □ No □	If yes, explain:
Bleeding between periods?	Yes □ No □	If yes, explain:
Menstrual cramps/pain which affected your school or athletic performance?	Yes □ No □	If yes, explain:
Have you ever gone more than 3 months between periods?	Yes □ No □	If yes, explain:
Have you ever seen a medical clinician/physician because of irregular periods?	Yes □ No □	If yes, explain:

HEAD AND NEUROLOGICAL MEDICAL HISTORY		
Have you suffered a concussion?	Yes □ No □	If yes, how many concussions?
Experienced loss of Consciousness?	Yes □ No □	If yes, how many times, and duration (how long)?
Has anyone ever used the word "dinged/bell rung" to describe a head injury?	Yes □ No □	If yes, explain:
Long term problems due to head injury such as memory loss, headaches, dizziness, mood swings, and/or nausea?	Yes □ No □	If yes, explain:
Have you had numbness, tingling, or weakness in the following areas: • Shoulder • Buttocks • Legs and/or feet	Yes □ No □	If yes, explain:
Seizure or epilepsy	Yes □ No □	If yes, explain:
Migraine headaches	Yes □ No □	If yes, explain:
Have you ever taken a baseline neuro-psych test?	Yes □ No □	If yes, which one (e.g. CogState, ImPact, etc.)? Please include a copy of the test results.
Have you ever been told to refrain from sport participation due to concussion(s)?	Yes □ No □	

THE UNDERSIGNED, HEREWITH,

- Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written allowance by the attending physician to resume participation;
- Certifies that the answers to these questions are correct and true;
- Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her;
- Fully realizes that the Baton Rouge Soccer Club and the Sports Medicine Program cannot be held responsible for any previous medical condition(s), or for any current medical conditions that he/she has, that may or may not have been previously diagnosed;
- Grants permission for the physical screening evaluation and understand the evaluation involves a limited examination and the screening is not intended to, nor will it, prevent injury or sudden death;
- Further understands that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer healthcare provider and/or employer under Louisiana law;
- This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the athlete named above, is done so in compliance with Louisiana law with the full understanding that there shall be no cause of action for any loss or damage caused by any act or omission related to the healthcare services if rendered voluntarily and without expectation of payment herein unless such loss or damage was caused by gross negligence;
- By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the BRSC Director of Sports Medicine.

_____ _____ _____ _____

Signature of Athlete (if 18 years of age or older) Date Signature of parent/guardian Date

DO NOT FILL OUT BELOW THIS LINE. PROVIDER USE ONLY

ORTHOPEDIC HISTORY Has the athlete had any injuries to the following areas?											
Yes	**No**	**Condition**	**Date**	**Yes**	**No**	**Condition**	**Date**	**Yes**	**No**	**Condition**	**Date**
		Traumatic or stress fracture				Arm/Wrist/Hand/ Left/Right				Foot L/R	
		Neck Injury/stinger				Chest				Chronic instability of joint (knee/ankle/shoulder/AC) L/R	
		Spine injury/Scoliosis				Hip L/R				Chronic "Shin Splints"	
		Pinched Nerve				Thigh L/R				Severe Muscle strain or ligament/tendon sprain	
		Back injury				Knee L/R				Injection(s)	
		Shoulder L/R				Lower Leg L/R				Congenital Deformity	
		Elbow L/R				Ankle L/R				Subluxation(s) and/or dislocation(s)	
		Previous surgeries		Surgery:							

PRE-PARTICIPATION PHYSICAL EXAM			
Height:	Weight:	Blood Pressure:	Pulse:

GENERAL MEDICAL EXAM:			
	NORMAL	ABNORMAL	COMMENTS
ENT			
Lungs			
Heart			
Abdomen			
Skin			
Hernia (if necessary)			
ORTHOPAEDIC EXAM:			
SPINE/NECK:			
	NORMAL	ABNORMAL	COMMENTS
Cervical			
Thoracic			
Lumbar			
UPPER EXTREMITY:			
	NORMAL	ABNORMAL	COMMENTS
Shoulder			
Elbow			
Wrist/hand/fingers			
LOWER EXTREMITY:			
	NORMAL	ABNORMAL	COMMENTS
Hip			
Knee			
Ankle			

From this limited screening I see no reason why this athlete cannot participate in athletics.

□ Athlete is cleared
□ Athlete is cleared after further evaluation and treatment for:_____
□ Athlete is not cleared

_____ _____ _____
Printed name of MD, DO, APRN, or PA Signature of MD, DO, APRN, or PA Date

This physical expires one year on the last day of the month that it was signed and dated by the MD, DO, APRN, or PA.