

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>
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Part A - Health History (to be completed by athlete and parent)

	1. Have you ever been hospitalized? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	2. Have you ever had surgery?	YES	NO
	3. Are you presently taking and medication? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	4. Do you have allergies to medication or insects?	YES	NO
	5. Have you ever been dizzy during or after exercise? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	6. Have you ever had chest pain during or after	YES	NO
	7. Do you tire more quickly than your friends during exercise? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	8. Have you ever been told you had a heart murmur, high blood pressure, or a heart problem?	YES	NO
	9. Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	10. Has anyone in your family died of heart problems or sudden death before age 50?	YES	NO
	11. Do you have any skin problems (itching, rashes, acne) ? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	12. Have you ever had a head injury?	YES	NO
	13. Have you ever had a seizure, been knocked out, or unconscious? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	14. Have you ever had a stinger, burner, or pinched nerve?	YES	NO <input type="checkbox"/>
	15. Have you ever had heat or muscle cramps? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	16. Have you ever been dizzy or passed out in the heat?	YES	NO
	17. Do you have trouble breathing or cough during or after activity? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	18. Do you use any special equipment (pads, braces, etc-this does not include standard protective equipment)?	YES	NO
	19. Have you had any problems with your eyes or vision? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	20. Have you had any other medical problems (diabetes, asthma, etc)?	YES	NO
	21. Have you had an illness/injury since your last physical? <input type="checkbox"/>	YES	NO <input type="checkbox"/>
	22. Are you missing any organs (kidney, testicle, ovary, etc)?	YES	NO
	23. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints (if yes, circle the affected joint(s))?	YES	NO <input type="checkbox"/>
	Shoulder Elbow Wrist Hand Hip Knee Shin/Calf Ankle Foot Neck <input type="checkbox"/>		

For Women:

	1. At what age did you experience your first menstrual period? _____ <input type="checkbox"/>		
	2. In the last year, what is the longest time you have gone between periods? <input type="checkbox"/>		
	Explain any YES answers:		

Signature of Parent	/ Signature of Athlete <input type="checkbox"/>
Date	/ Date

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)</i>	REGISTER NO.	WARD NO.
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CHRONOLOGICAL RECORD OF MEDICAL CARE
 Medical Record
STANDARD FORM 600 (REV. 6-97)
 Prescribed by GSA/ICMR
 FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>			
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Part B - Physical Examination (To be completed by Health Care Provider)

Name:	Date:	Age:	Birth Date:
Height:	VISION		
Weight:	Right Eye		Left Eye
BMI:	Corrected Uncorrected /	/	Corrected Uncorrected /

Pulse:	BP:	Resp:				
	NORMAL	ABNORMAL FINDINGS	Initials			
1. Eyes						
2. Ears, Nose, Throat						
3. Mouth & Teeth						
4. Neck						
5. Cardiovascular						
6. Chest & Lungs						
7. Abdomen						
8. Skin						
9. Genitalia - Hernia						
10. Musculoskeletal: ROM, strength						
a. neck						
b. spine (scoliosis check)						
c. shoulders						
d. arms/hands						
e. hips <input type="checkbox"/>						
f. thighs						
g. knees <input type="checkbox"/>						
h. ankles						
i. feet						
11. Neuromuscular						
12. Physical Maturity (Tanner Stage)	1	2	3	4	5	

Comments concerning Abnormal Findings:

PARTICIPATION RECOMMENDATIONS:

No participation in:

Limited participation in:

Requires:

Full participation in:

Physician's Signature:

Date: