

Xavier University Medical History

(For participation in Club Sport program)

Name: _____ SS #: _____ Date of Birth: / / Sex: _____ Requested Sports: _____

- This section is to be carefully completed before participation in the Xavier University Club Sport program in order to help detect possible risks.
- Explain "Yes" answers below. Circle questions you don't know the answer to.

	YES	NO		YES	NO
Injury or illness since last physical?	___	___	Irregularities in bowel or urinary habits?	___	___
Chronic or recurrent illness?	___	___	Hearing difficulties?	___	___
Illness lasting over one week?	___	___	Sudden changes in weight/special diet?	___	___
Hospitalizations?	___	___	Vision problems?	___	___
Surgeries?	___	___	Wear corrective lenses?	___	___
Missing organs?	___	___	Wear dental bridges, braces, plates?	___	___
Take any medications?	___	___	Injuries requiring Dr. treatment?	___	___
Allergies to any medications?	___	___	Neck injury (chronic/acute)?	___	___
Problems with heart or blood pressure?	___	___	Back injury (chronic/acute)?	___	___
Complications during exercise:			Knee injury (chronic/acute)?	___	___
Chest pain or heart murmur?	___	___	Ankle injury (chronic/acute)?	___	___
Dizziness or fainting?	___	___	Shoulder injury (chronic/acute)?	___	___
Breathing?	___	___	Any surgeries?	___	___
Concussions or unconsciousness?	___	___	Other joint injuries?	___	___
Problems with dizziness, headaches, fainting or convulsions?	___	___	Broken, fractured or dislocated bones?	___	___
Heat exhaustion, heatstroke or heat related problem?	___	___	Has a family member died suddenly at less than 40 years of age?	___	___
Bruise easily or nose bleeds?	___	___	Last date of Tetanus shot: ___/___/___		
Asthma or allergies/ breathing irregularities?	___	___			

Use this space to explain any of the above numbered YES answers, provide additional information or list any other medical problem:

Everything I have provided is true to the best of my knowledge.

Signed _____ Date: _____

Date: _____

Xavier University Physical Exam

(For participation in Club Sport program)

Name: _____ Birth Date: _____ Height: _____ Weight: _____

Pulse: _____ Blood Pressure: _____ Vision: Right _____ Left _____ Corrected: Y N

Comments:

	Normal	Abnormal	Not Examined	Comments	Examiner
1. Eyes					
2. Ears, nose, throat					
3. Mouth and teeth					
4. Neck (soft tissue)					
5. Cardiovascular					
6. Chest and lungs					
7. Abdomen					
8. Genitalia – hernia					
9. Skin and lymphatics					
10. Neck					
11. Spine					
12. Shoulders					
13. Arms and hands					
14. Hips					
15. Thighs					
16. Knees					
17. Ankles					
18. Feet					
19. Neurological					

Participation Recommendations

- No history or physical findings on this exam would prohibit this student from participating in the requested sports.
- This student should have the following health problems evaluated or treated before participation recommendations can be made.
- This student has health problems that prohibit him or her from participating in the requested sports.

Reasoning/Comments:

Physician