UNIVERSITY OF WISCONSIN-OSHKOSH SPORTS MEDICINE

ANNUAL ATHLETIC PHYSICAL UPDATE

NAME:	School ID#:	SMOKER: Yes No	SEX: M F
SPORT:		CLASS: FRESH SOPH JR SR 5TH	
LAST PHYSICAL EXAM:		Campus Email:	@uwosh.edu
LOCAL ADDRESS:		LOCAL PHONE:	
		CELL PHONE:	

MEDICAL HISTORY:	**In the past year,** have you had, or do you now have:		
RESPIRATORY/HEART:			**Circle the correct answer:**
Breathing difficulty/cough with exercise or asthma?	NO	Currently	Last 12 months
Chest pain with exercise?	NO	Currently	Last 12 months
Have you ever had a heart murmur?	NO	Currently	Last 12 months
Racing of your heart/skipped beats?	NO	Currently	Last 12 months
Fainting/passing out with exercise?	NO	Currently	Last 12 months
Any family members with heart problems?	NO	Currently	Last 12 months
HEAD:			
Any chipped or loose teeth	NO	Currently	Last 12 months
Any type of eye trouble?	NO	Currently	Last 12 months
Recurrent headaches?	NO	Currently	Last 12 months
Lightheadedness/dizziness/fainting with exercise?	NO	Currently	Last 12 months
ABDOMEN:			
Abdominal pain/nausea/vomiting/weight loss?	NO	Currently	Last 12 months
FATIGUE:			
Do you tire more quickly than your teammates?	NO	Currently	Last 12 months
Mononucleosis?	NO	Currently	Last 12 months
MISCELLANEOUS:			
Have you been hospitalized?	NO	Currently	Last 12 months
Have you had surgery including bone/joint repair?	NO	Currently	Last 12 months
Have you had a surgery other than orthopedic?	NO	Currently	Last 12 months
Are you taking any over-the-counter medications?	NO	Currently	Last 12 months
Do you have any sores or rashes?	NO	Currently	Last 12 months
Have you had any allergic reactions to medication(s) or insects?	NO	Currently	Last 12 months
Is any doctor presently treating you for any disorder?	NO	Currently	Last 12 months
Have you ever had a stress fracture?	NO	Currently	Last 12 months
CHRONIC ILLNESS (DO YOU HAVE):			
High Blood Pressure	NO	Currently	Last 12 months
Diabetes	NO	Currently	Last 12 months
Seizures	NO	Currently	Last 12 months
High cholesterol	NO	Currently	Last 12 months
Do you smoke or use smokeless tobacco?	NO	Currently	Last 12 months
Have any family members died before age 55?	NO	Currently	Last 12 months
FEMALE ATHLETES ONLY:			
When did your last menstrual period begin?			
What was the longest time between your periods in the last year?			
Do you perform self-breast exams?	NO	YES	
MALE ATHLETES ONLY:			
Do you do a regular testicular self exam?	NO	YES	

DIET HISTORY: Do you have/Have you ever had:				
Anorexia/bulimia/eating disorder?	PAST	PRESENT	NO	If yes, explain:
Have you ever induced vomiting to control your weight?	PAST	PRESENT	NO	
Do you want to weigh more/less than you do?	NO	YES		
Are you taking any vitamins, minerals, or supplements?	NO	YES		
Are there any food groups you choose not to eat (meat, dairy, etc.)?	NO	YES		
WHAT IS YOUR IDEAL WEIGHT?				

INJURY HISTORY: **In the past year have you had an injury of:**		**If YES, DATE**	**SIDE**		**Current Problem**	**Describe:**
HEAD (concussion - knocked out, surgery, hospitalization, other)	NO	YES	Lt	Rt	YES	
FACE (fracture, eye injury, ear problem, broken nose - deviated septum, other)	NO	YES	Lt	Rt	YES	
NECK (strain, fracture, stinger/burner, surgery, other)	NO	YES	Lt	Rt	YES	
SHOULDER (dislocation, separation, rotator cuff injury, tendonitis, surgery, other)	NO	YES	Lt	Rt	YES	
ELBOW (joint sprain, muscle strain, fracture, tendonitis, dislocation, surgery, other)	NO	YES	Lt	Rt	YES	
ARM (joint sprain, muscle strain, fracture, tendonitis, dislocation, surgery, other)	NO	YES	Lt	Rt	YES	
WRIST/THUMB/HAND (sprain, fracture, tendonitis, surgery, other)	NO	YES	Lt	Rt	YES	
FINGER(S) (sprain, fracture, surgery, other)	NO	YES	Lt	Rt	YES	
CHEST (lung injury, heart injury, other)	NO	YES	Lt	Rt	YES	
ABDOMEN (kidney injury, spleen injury, liver injury, other	NO	YES	Lt	Rt	YES	
GENITALIA (groin, testicle - ovary, other)	NO	YES	Lt	Rt	YES	
BACK (strain, chronic pain, slipped disc, surgery, other)	NO	YES	Lt	Rt	YES	
HIP/THIGH (fracture, muscle strain, calcium deposit, surgery, other)	NO	YES	Lt	Rt	YES	
KNEE (sprain, cartilage, pain, bursitis, tendonitis, surgery, other)	NO	YES	Lt	Rt	YES	
LOWER LEG (sprain, fracture, surgery, other)	NO	YES	Lt	Rt	YES	
ANKLE (sprain, fracture, tendonitis, other)	NO	YES	Lt	Rt	YES	
FOOT (sprain, fracture, plantar fasciitis - heel spur, surgery, other)	NO	YES	Lt	Rt	YES	
TOE(S) (fracture, surgery, other)	NO	YES	Lt	Rt	YES	

GENERAL INFORMATION:

Have you used/are you using any type of performance-enhancing substances or drugs?	PAST	PRESENT	NO	
Have you had an illness or injury in the last 12 months that has not been listed?	NO	YES		
Do you know of any health reason why you should not participate in the UW Oshkosh intercollegiate athletic program at this time?	NO	YES		

List current prescribed medications:	**Drug Allergies:**

ANNUAL ATHLETIC HEALTH HISTORY UPDATE DISCLAIMER

THE UNDERSIGNED, HEREWITH:

A. Understands that he or she must refrain from participation while ill or injured, whether or not receiving medical treatment, and during medical treatment until he or she is discharged from treatment or is given permission by the healthcare provider to restart participation despite continuing treatment.

B. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find medical reason to disqualify him or her at the time of said exam.

C. Certifies that the answers to the preceding questions are correct and true.

D. Understands this physical update is for no other purpose than to clear me for athletic participation at UW Oshkosh. I understand it is not a physical for illnesses, which may develop in the future. I further agree that such illnesses will be taken to the Student Health Center, my personal healthcare provider, or the athletic trainer for referral and care.

E. Give authorization to the athletic trainer or team physician to evaluate and treat any injuries that occur during athletic participation at UW Oshkosh. This includes immediate first aid treatment, x-ray, physical exam, follow-up care and rehabilitation. I understand the team physician and the athletic trainer have the authority to eliminate me from further participation because of an injury and/or because of an undue risk to UW Oshkosh. No records will be released to anyone other than the team physician and athletic trainer unless given my prior approval.

Athlete Signature_____ Date: _____

Below to be completed by the medical staff.

Ht:	**Wt:**	**BMI:**	**Peak Flow:**	**AT initials/date:**
PR:	**RR:**		**Vision Corrected: Y N** **R 20/_____ L 20/_____** **Unequal Pupils: Y N** **___ > ___** **Peripheral: N ABN**	**BP:**
LUNG & CARDIOVASCULAR EXAM: **Pulmonary: CLEAR ABNORMAL** **CV: RHYTHM: REGULAR IRREGULAR** **MURMURS: NONE GRADE**				**Date: BP:** **Date: BP:** **Date: BP:**
PROVIDER COMMENTS:				

Approved for Participation	**Yes**	**No**
Provider signature:		Date:

Functional Movement Screen

Deep Squat		Performed by:	Initials
III	• Upper Torso and Tibia are parallel toward vertical • Femur Below Horizontal • Knees aligned over feet • Dowel Aligned over feet		
II	• Upper Torso is parallel with tibia or toward vertical • Femur Below Horizontal • Knees Aligned over feet • Dowel Aligned over feet		
I	• Tibia and Upper Torso are not parallel • Femur below Horizontal • Knees are not aligned over feet • Lumbar flexion noted		
0	• Pain		

Special Note: If athlete unable to break 90 Degrees, Add board under heels.

- If they break parallel, ankle issue
- If still not parallel, hip problem
- Score of 0 for pain

Shoulder Mobility		Performed By:	Initials
III	• Fists should be within one hand length	Left	Right
II	• Fists should be within 1.5 hand length		
I	• Fists fall within two hand lengths		
O	• Pain		

Special Note: Perform Impingement Test → Crossover arm to opposite shoulder, raise elbow

- Score of O for Pain
- Grade to the Lowest Score