

Patient name _____		_____		_____		_____		Soc. Sec. # _____	
Legal name _____		Last _____		First _____		Middle initial _____			
Alternative names/maiden/nicknames _____					Hispanic/Latino Ethnical Background <input type="checkbox"/> Yes <input type="checkbox"/> No				
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth date _____		Race _____					
Marital status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		Email _____							
Military status <input type="checkbox"/> Active Duty <input type="checkbox"/> Retired <input type="checkbox"/> Veteran <input type="checkbox"/> Never Served									
Address _____		_____		_____		_____		_____	
Street		PO Box		City		State		Zip	
Home phone () _____			Work phone () _____			Cell phone () _____			
Employer _____					Occupation _____				
Employer address _____		_____		_____		_____		_____	
Street		PO Box		City		State		Zip	
Spouse's name _____				Birth date _____			Soc. Sec. # _____		
Employer _____				Occupation _____					
Work phone () _____				Cell phone () _____					
Employer address _____		_____		_____		_____		_____	
Street		PO Box		City		State		Zip	
RESPONSIBLE PARTY / BILLING INFORMATION (If patient is a minor)									
Mother's name _____				Birth date _____			Soc. Sec. # _____		
Address _____		_____		_____		_____		_____	
Street		PO Box		City		State		Zip	
Home phone () _____				Work phone () _____					
Employer _____				Occupation _____			Cell phone () _____		
Employer address _____		_____		_____		_____		_____	
Street		PO Box		City		State		Zip	
Father's name _____				Birth date _____			Soc. Sec. # _____		
Address _____		_____		_____		_____		_____	
Street		PO Box		City		State		Zip	
Home phone () _____				Work phone () _____					
Employer _____				Occupation _____			Cell phone () _____		
Employer address _____		_____		_____		_____		_____	
Street		PO Box		City		State		Zip	
EMERGENCY CONTACT									
Name _____					Relationship to patient _____				
Address _____		_____		_____		_____		_____	
Street		PO Box		City		State		Zip	
Home phone () _____			Work phone () _____			Cell phone () _____			



PIONEER MEMORIAL
VIBORG MEDICAL CLINIC

PATIENT INFORMATION
VMC 2005
Revised 3/8/2022

NAME _____
DOB _____

SDHSAA HEALTH HISTORY FORM - To be completed (with parent/guardian if student is under 18) in years when a physical exam is given, prior to the exam.

Name: _____

Date of Birth: _____

Date of Exam: _____

Sports: _____

List all past and current medical conditions:	
Have you ever had surgery? If Yes, list all procedures:	
List all prescriptions, over-the-counter meds or supplements you currently take:	
Do you have any allergies? If Yes, Please list them here:	

Over the last two weeks, how often have you been bothered by the following problems? (Circle Response)

	Not At All	Several Days	Over Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest in pleasure or doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

A sum of 3 or greater is considered positive on either subscale (Q1+2, or Q3+4) for screening purposes

ANSWER EACH OF THE FOLLOWING QUESTIONS SPECIFIC TO "IN THE PAST YEAR"

& EXPLAIN ANY YES ANSWERS ON THE BACK OF THIS SHEET:

GENERAL QUESTIONS	Yes	No	BONE AND JOINT QUESTIONS, CONTINUED:	Yes	No
1. Do you have any concerns you'd like to discuss with your provider?			15. Do you have a bone, muscle, ligament or joint injury that bothers you?		
2. Has a provider ever denied or restricted your participation in sports for any reason?			MEDICAL QUESTIONS	Yes	No
3. Do you have any ongoing medical issues or recent illnesses?			16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	17. Are you missing a kidney, an eye, a testicle, your spleen or any other organ?		
4. Have you ever passed out or nearly passed out during or after exercise?			18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
5. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?			19. Do you have recurring skin rashes or rashes that come and go, including herpes or MRSA?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
7. Has a doctor ever told you that you have any heart problems?			21. Have you ever had numbness, tingling or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
8. Has a doctor ever requested a test for your heart? (Example: electrocardiography or echocardiography)			22. Have you ever become ill while exercising in the heat?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			23. Do you or does someone in your family have sickle cell trait or disease?		
10. Have you ever had a seizure?			24. Have you ever had, or do you have any problems with your eyes or vision?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	25. Do you worry about your weight?		
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before 35 years of age (including drowning or unexplained car crash)			26. Are you trying to, or has anyone recommended that you gain or lose weight?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS) short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			27. Are you on a special diet, or do you avoid certain types of foods or food groups?		
13. Has anyone in your family had a pacemaker or implanted defibrillator before age 35?			28. Have you ever had an eating disorder?		
BONE AND JOINT QUESTIONS	Yes	No	29. Have you ever had COVID-19?		
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or a game?			FEMALES ONLY	Yes	No
			30. Have you ever had a menstrual period?		
			31. How old were you when you had your first period?		
			32. When was your most recent period?		
			33. How many periods have you had in the past 12 months?		

CERTIFICATION OF HEALTH: I hereby state that, to the best of my knowledge, my answers on this form are complete and correct:

Signature of Athlete: _____

Signature of parent/guardian (if under 18): _____

Date: _____

SDHSAA PREPARTICIPATION PHYSICAL EXAM FORM

Athlete Name: _____ Date of Birth: _____
 Date of Exam: _____ Annual/Biennial/Triennial: _____

Physician Reminders:

1. Consider additional questions on more sensitive issues:
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, vaping, chewing tobacco, snuff or dip?
 - Over the past 30 days, have you used chewing tobacco, snuff or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seatbelt or helmet?
2. Consider reviewing questions on cardiovascular symptoms (#4-13 on health history form)

EXAMINATION		
Height:	Weight:	BP:
Pulse:	Vision: R 20/ L 20/	Corrected?:

MEDICAL	Normal	Abnormal Findings
Appearance		
Head/Mouth		
Eyes, ears, nose and throat - Pupils equal & Hearing		
Lymph Nodes		
Heart* -Heart sounds, murmurs, pulse, rhythm, auscultation		
Lungs		
Abdomen - Liver/Spleen, masses		
Skin - HSV, Lesions, Staph, MRSA, etc.		
Neurological		
MUSCULOSKELETAL	Normal	Abnormal Findings
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, Hand and Fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional		
• Double-leg squat test, single-leg squat test, box drop or step drop test		

* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or exam findings, or a combination

Sports Participation Recommended for (Mark One):

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendation for further evaluation or treatment of: _____
- Medically eligible for certain sports (list here): _____
- Not medically eligible pending further evaluation: _____
- Not medically eligible for any sports: _____

Name of Examiner: _____
 Signature of Examiner: _____
 Date of Exam: _____

Note: SDCL allows Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Licensed Physician Assistant and Licensed Nurse Practitioners as those that can provide this recommendation.

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