



STUDENT-ATHLETE MEDICAL HISTORY AND PHYSICAL FORM

Student-Athlete/Parent should complete Page 1 & 2 only. The physician will complete Pages 3 and 4.

Date: _____ Sport: Men's _____ Women's _____ Age: _____ Sex: _____

All information is confidential and is retained exclusively for the use of George Mason University's Athletic Department

Name: _____ Date of Birth: _____

Student G Number _____

PERMANENT ADDRESS

Street: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Do you have an absence or loss of function in any of the following body parts?

<input type="checkbox"/> Eye	<input type="checkbox"/> Ear	<input type="checkbox"/> Lung	<input type="checkbox"/> Internal Organ	<input type="checkbox"/> Genital Organ	<input type="checkbox"/> Kidney	<input type="checkbox"/> Other
Explain: _____						

Please check (Y) Yes or (N) No and provide appropriate dates and explanations for all items listed below:

Prior occurrence of chest pain/discomfort during exercise?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Prior occurrence of fainting/dizziness with exercise?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Unexplained/unexpected shortness of breathe or fatigue with exercise?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Heart murmur? High or low blood pressure ?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Personal or family history of seizures?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Frequent headaches?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Family history of sudden death?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Younger than 50 yrs. old Yes _____ No _____ (Check)
Family history of heart disease?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Younger than 50 yrs. old Yes _____ No _____ (Check)
Family history of Marfan's Syndrome?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
History of Rheumatic Fever?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Personal or Family history of diabetes?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Personal or Family history of sickle cell disease or sickle cell trait?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Weight change of 5lbs. or more?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
History of irregular menstrual cycle?	<input type="checkbox"/> Y	<input type="checkbox"/> N	# of cycles in past yr: _____
Are you pregnant?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Heat exhaustion/Heat stroke?	<input type="checkbox"/> Y	<input type="checkbox"/> N	When: _____
Concussion or other head and/or neck injury? When?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Surgery or serious illness? When?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Shoulder injury? When?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Elbow, wrist, or hand injury? When?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Back and/or hip injury? When?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Knee injury? When?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Lower leg, ankle, and/or foot injury? When?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Other injury? When?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Explain: _____
Do you wear corrective lenses?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Contacts? Yes _____ No _____ (Check)
Are you now under a doctor's care?	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, for what condition?
Do you have asthma? Do you use an inhaler?	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, pls. complete questionnaire on pg 2.
Please list all medications you are currently taking: _____			
Please list all supplements (including vitamins) you are currently taking: _____			
Please list all allergies (medications, food, pollen, other): _____			

SIGNATURE OF PERSON COMPLETING THIS FORM _____

DATE _____

Name: _____ Date of Physical _____

STUDENT-ATHLETE ASTHMA QUESTIONNAIRE:

At what age were you diagnosed?
What are your medications for asthma?
Have your medications changed during the past 12 months?
Have you visited the emergency room or your primary doctor for breathing difficulty in the past 12 months?
How often do you use your inhaler for shortness of breath every week?

PHYSICIAN REFERENCES FOR HEART EXAM AND MARFAN'S SYNDROME SCREENING:

****It is important to auscultate heart sounds dynamically. Maneuvers that decrease venous return (such as the Squat-to-Stand Maneuver, or the Release Phases (III and IV) of the Valsalva maneuver) may uncover or accentuate the murmur hypertrophic cardiomyopathy, and attenuate the murmur of aortic stenosis. Maneuvers that increase venous return (such as the Stand-to-Squat Maneuver or the Straining Phases (I and II) of Valsalva Maneuvers) may uncover or accentuate the murmur of aortic stenosis and attenuate the murmur of hypertrophic cardiomyopathy.**

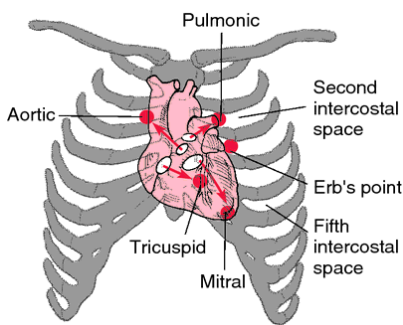


Table 1	GRADING HEART MURMURS
Grade	Description
1	Soft murmur heard only under quiet conditions
2	Soft murmur heard under even noisy conditions
3	Easily heard prominent murmurs
4*	Loud murmur associated with a thrill
5	Loud murmur with the edge of the stethoscope tilted against the chest plus a thrill
6	Very loud murmur that can be heard 5 mm to 10 mm from the chest plus a thrill

**Note: Diastolic murmurs are only graded to grade 4*

Innocent vs. Pathologic Murmurs

Innocent

- ☐ Systolic
- ☐ Ejection
- ☐ Soft or vibratory
- ☐ Grade 1-2/6
- ☐ Normal S1, S2
- ☐ No extra sounds
- ☐ Louder supine

Pathologic

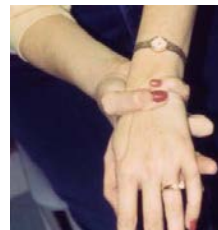
- ☐ Diastolic
- ☐ Holosystolic
- ☐ Harsh
- ☐ Grade \geq 3/6
- ☐ Abnormal split S2
- ☐ Extra sounds "click"
- ☐ Louder with standing

2 Scoring of systemic features for the diagnosis of Marfan syndrome*

Feature	Score
Wrist OR thumb sign ¹	1
Wrist AND thumb sign ¹	3
Pectus carinatum deformity	2
Hindfoot deformity	2
Plain pes planus	1
Pectus excavatum or chest asymmetry	1
Pneumothorax	2
Dural ectasia	2
Protrusio acetabulae	2
Reduced upper segment to lower segment ratio, ² AND increased ratio of arm span to height ³ AND no severe scoliosis	1
Scoliosis or thoracolumbar kyphosis	1
Reduced elbow extension	1
Three of the five typical facial features (dolichocephaly, enophthalmos, downward slanting palpebral fissures, malar hypoplasia, retrognathia)	1
Skin striae	1
Myopia of > 3 dioptres	1
Mitral valve prolapse	1

-Upper/Lower Segment Ratio < 0.85 in whites, <0.78 in blacks AND Increased Arm Span/Height > 1.05 contributes **1 point** to systemic score.

-Positive wrist (Walker) and thumb (Steinberg) signs: Two simple maneuvers may help demonstrate arachnodactyly. First, the thumb sign is positive if the thumb, when completely opposed within the clenched hand, projects beyond the ulnar border. Second, the wrist sign is positive if the distal phalanges of the first and fifth digits of one hand overlap when wrapped around the opposite wrist.



Name: _____ Date of Physical _____

VITAL SIGNS

Blood Pressure: _____ Pulse: _____ Weight: _____ Height: _____

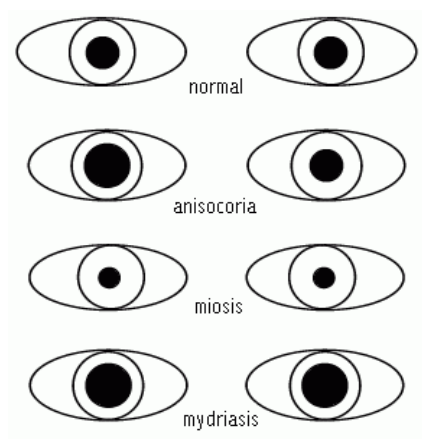
EXAMINATION:

H.E.E.N.T. –

Anisocoria* Yes No

Skin –

Lungs –



Heart (Please provide details of heart exam; WNL not acceptable)**See pg 2 for additional information

Supine Exam: _____

Squat to Stand / Valsalva Exam: _____

Radial-Femoral Pulse Assessment: _____

Recognition of Marfan's Syndrome***See pg 2 for additional information

Kyphoscoliosis Yes No

Thumb Sign Yes No

Wrist Sign Yes No

Other: _____

Neck/Back –

Abdomen –

Upper Extremities –

Lower Extremities –

Nervous System –

Name: _____ Date of Physical: _____

PHYSICIAN RECOMMENDATIONS:

- ☐ Cleared for all athletic participation
- ☐ Requires further evaluation prior to participation (see below)

- ☐ May participate with restrictions, but further evaluation required. (see below)

- ☐ May participate without restrictions, but further evaluation required. (see below)

- ☐ Disqualified (see below)

Name of Examining Physician: _____

Address: _____

Telephone: _____

Signature of Examining Physician: _____ Date: _____

Please return this form to:

George Mason University
Recreation – Club Sports
RAC, Room 1112, MS 1G6
Fairfax, Virginia 22030-4444
Office: (703) 993-5819 Fax: (703) 993-2510