



**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 Recreation 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.

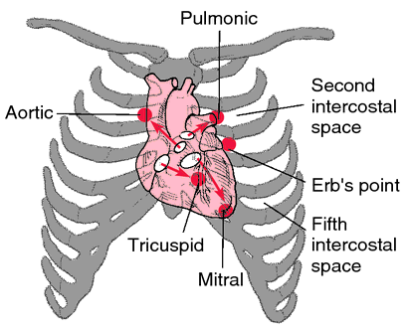


Table 1 GRADING HEART MURMURS	
Grade	Description
1	Soft murmur heard only under quiet conditions
2	Soft murmur heard under even noisy conditions
3	Easily heard prominent murmurs
4*	Loud murmur associated with a thrill
5	Loud murmur with the edge of the stethoscope tilted against the chest plus a thrill
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	Pathologic
<input type="checkbox"/> Systolic	<input type="checkbox"/> Diastolic
<input type="checkbox"/> Ejection	<input type="checkbox"/> Holosystolic
<input type="checkbox"/> Soft or vibratory	<input type="checkbox"/> Harsh
<input type="checkbox"/> Grade 1-2/6	<input type="checkbox"/> Grade $\geq$ 3/6
<input type="checkbox"/> Normal S1, S2	<input type="checkbox"/> Abnormal split S2
<input type="checkbox"/> No extra sounds	<input type="checkbox"/> Extra sounds "click"
<input type="checkbox"/> Louder supine	<input type="checkbox"/> Louder with standing

2 Scoring of systemic features for the diagnosis of Marfan syndrome*	
Feature	Score
Wrist OR thumb sign <sup>1</sup>	1
Wrist AND thumb signs <sup>1</sup>	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, <sup>2</sup> AND increased ratio of arm span to height <sup>2</sup> 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: \_\_\_\_\_

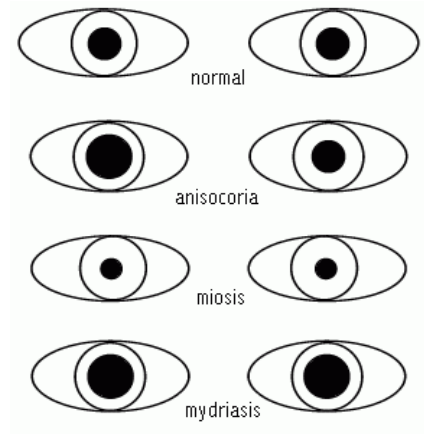
**EXAMINATION:**

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)

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

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- Disqualified (see below)

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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