USS SPORTS MEDICINE COMPREHENSIVE REVIEW

Name:____Date of Birth:________________Date of Exam:_________________

Local Address (Street, City, State, Zip):____

Phone Number:_______________________   Email Address:____

Emergency Contact (Name, Relationship):__________________________________Emergency Contact Phone Number:_________________

Sex (assigned at birth): ☐ Male ☐ Female ☐ Other ☐ Prefer Not to Say

PERSONAL BACKGROUND

Date of your last physical exam:________________________________Date of your last dental exam:_____________________

Have you ever failed a physical? ☐ Yes ☐ No (If Yes, why?) ____

Estimate how many training sessions and/or competition races in the last year you missed due to injury/illness:__________________

(Explain) ____

Do you have any current TUE's (Therapeutic Use Exemption) filed? ☐ Yes ☐ No

(If Yes, what medication & date filed):____

Have you ever participated competitively in another sport? ☐ Yes ☐ No (If Yes, what sport & when):____________________________

MEDICATIONS AND SUPPLEMENTS (LIST BELOW. IF NONE, WRITE "N/A")

NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN (IF APPLICABLE)
i.e. OTC Ibuprofen	400mg	2-3x/week	N/A

ALLERGIES (pollen, foods, medication, plant or animal material) ☐ YES ☐ NONE (IF YES, WRITE NAME AND REACTION IF EXPOSED)

NAME	REACTION

IMMUNIZATION RECORD

☐ Tetanus/Diphtheria (TD or TDAP) Date:	☐ Measles/Mumps/Rubella (2 shots) Dates:	☐ Chicken Pox (Varicella) Date:	☐ Meningitis (Menomune or Menactra) Date:	☐ COVID-19 (1-2 shots) ☐ Booster (≥1 shot) Date(s):
☐ Hepatitis A (2 shots) Dates:	☐ Hepatitis B (3 shots) Dates:	☐ Malaria Date:	☐ TB Test Result: Date:	☐ Influenza (1 shot) Date:

Please list any additional information as needed: ____

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USSPEEDSKATING

REVIEW AND ANSWER THE FOLLOWING QUESTIONS. IF YOU ANSWER "YES," EXPLAIN AT THE DESIGNATED LINES.

	GENERAL MEDICAL	YES	NO
1	Do you have any concerns that you would like to discuss with a doctor?		
2	Do you or a family member have any ongoing or past medical conditions? ☐Asthma ☐Diabetes Mellitus ☐Infections ☐Dyslipidemia ☐Tuberculosis or Hepatitis ☐Hypoglycemia ☐Thyroid Gland Disorders ☐Anemia		
3	Do you or a family member have sickle cell trait or disease, abnormal bleeding or clotting disorder, embolus (blood clot), or other bleeding disorder?		
4	Have you ever had arthritis or joint pain, swelling and redness not related to injury?		
5	Have you ever spent the night in the hospital?		
6	Have you ever had surgery?		
7	Have you ever had an injection for an injury or illness?		
8	Were you born without or are you missing: kidney, eye, spleen, or any other organ?		
9	Do you have groin pain or a painful bulge or hernia in the groin area?		
10	Have you had infectious mononucleosis (mono), flu-like symptoms, or viral illness within the last month?		
11	Do you have any rashes, pressure sores, herpes, MRSA, or other skin problems?		
12	Do you have a past history or currently suffer from any symptoms of gastrointestinal disease including, but not limited to, heartburn, nausea, abdominal pain, a change in bowel habits, chronic diarrhea, or blood in the stools?		
13	Do you have the ability to adopt a protective behavior such as avoiding overly aggressive or high-risk situations?		
14	Have you ever had COVID-19?		
15	Do you have a past history or currently suffer from any symptoms of disease of the kidney or bladder including past history or kidney or bladder disease, blood in the urine, loin pain, kidney stones, frequent urination, or burning during urination?		
16	Do you have a past history or currently suffer from any symptoms of disease of the immune system including current infections, recurrent infections, HIV/AIDS, leukemia, or are you using any immunosuppressive medication?		
17	Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, venereal warts, or chlamydia?		

	RESPIRATORY & BREATHING	YES	NO
18	Do you have a past or current history of coughing, wheezing or difficulty breathing?		
19	Have you ever used an inhaler or taken asthma medication?		
20	Have you ever had postnasal drip, hay fever, or repeated flu-like illness?		
21	Have you ever had bronchitis, pneumonia, cystic fibrosis or any other breathing problems?		

	BONE AND JOINT	YES	NO
22	Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a competition?		
23	Have you ever broken, fractured, or dislocated joints/bones?		
24	Have you ever had an injury that required x-rays, MRI, CT scan, injections, cast or crutches?		
25	Have you ever been told that you have general instability or general laxity?		
26	Do you regularly use a brace, orthotics or an assistive device?		
27	Do you have any history of juvenile arthritis or connective tissue disease?		

	CARDIAC	YES	NO
28	Have you ever had exertional chest pain, discomfort, tightness or pressure?		
29	Have you ever had exertional syncope (passing out) or near syncope (almost passing out)?		
30	Have you ever had excessive or unexplained fatigue, lightheadedness, or shortness of breath with exercise?		
31	Does your heart race or skip beats (irregular beats) during exercise or at rest?		
32	Have you ever been told you or a family member has any of the following? ☐High Blood Pressure ☐Heart Murmur ☐High Cholesterol/Lipid ☐Rheumatic Fever ☐Heart Valve Problems ☐Kawasaki Disease ☐Heart Infection or Inflammation ☐Other		
33	Have you ever had any heart-related tests? (Echo, EKG/ECG, etc.)		
34	Has one or more relatives with disability or premature death (sudden and unexpected, or otherwise) before 50 years of age attributable to a heart disease?		
35	Does a family member have any of the following? ☐Hypertrophic/Dilated Cardiomyopathy ☐Long-QT Syndrome ☐Coronary Artery Disease ☐Marfan Syndrome ☐Other Ion Channelopathies ☐Clinically Significant Arrhythmias ☐Heart Surgery ☐Pacemaker or Defibrillator ☐Other ☐Specific Knowledge of Genetic Cardiac Conditions in Family Members		

	HEAT-RELATED ILLNESS	YES	NO
36	Have you ever become ill while exercising in the heat?		
37	Have you ever been diagnosed with exertional heat stroke, heat exhaustion, or hyperthermia?		
38	Do you get frequent muscle cramps when exercising?		
39	Have you trained in warm or humid weather within the past two weeks?		
40	When you sweat, can it be considered excessive or salty?		
41	Have you ever had electrolyte (salt) or fluid imbalance?		

Please explain "YES" answers here (*i.e. 14: Tested positive for COVID in April 2021, fever first day but then mainly cold-like symptoms, felt fine by day 4*): ______

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REVIEW AND ANSWER THE FOLLOWING QUESTIONS. IF YOU ANSWER "YES," EXPLAIN AT THE DESIGNATED LINES.

	HEAD AND NECK	YES	NO
42	Do you have a history or currently suffer from symptoms of eye disease or injury including decreased vision, pain in the eyes, itchy eyes, increased or decreased tear production, discharge from the eye or red eyes?		
43	Do you wear eyeglasses, contacts, or protective equipment of the eyes, head, or face?		
44	Do you get headaches with exercise?		
45	Have you ever had numbness, tingling or weakness in your arms and/or legs?		
46	Have you ever not been able to move your arms or legs after being hit or falling?		
47	Have you had cervical spine stenosis or a spinal cord injury?		
48	Do you, or anyone in your immediate family, have a history of a seizure disorder, stroke, or chronic fatigue?		
49	Have you ever been hit in the face, head or body that resulted in any of the following: headache, dizziness, nausea, vision or balance problems, sensitivity to light or sound, sadness, or head, orofacial or cervical spine injury?		
50	Have you ever been told that you have, or have you had an x-ray for, neck instability or atlantoaxial instability?		
51	Do you have a history or currently suffer from symptoms of disease of the ears (infections, hearing loss, pain), nose (sneezing, itchy nose, sinusitis, blocked nose), or throat (sore throat, hoarse voice, swollen glands in the neck)?		
52	Have you had any injury to your teeth?		
53	Do you have a dental prosthesis or appliance?		
54	Have you had your wisdom teeth removed?		

	MODIFIED TCRAT	YES	NO
55	Do you worry about your weight?		
56	Are you trying to or has anyone recommended that you gain or lose weight?		
57	Are you on a special diet or do you avoid certain types of foods or food groups?		
58	Have you ever had an eating disorder?		
59	Have you ever had a stress fracture?		
60	Have you ever been told you have low bone density (osteopenia or osteoporosis)?		
61	Do you eat in secret?		
62	Do you use extreme dehydration as a weight loss technique?		
63	Are you worried you have lost control over how much you eat?		

	FEMALES ONLY	YES	NO
64	Have you ever had a menstrual period?		
65	How old were you when you had your first menstrual period?		y.o.
66	When was your most recent menstrual period?		
67	How many periods have you had in the past 12 months?		
68	Are you presently prescribed and taking any female hormones (IUD, injection, patch, pills, etc.)?		

	MALES ONLY	YES	NO
69	Have you recently or do you currently have a loss of sexual drive or change in libido?		
70	Have you been diagnosed with low testosterone?		

Please explain "YES" answers here (*i.e. 54: removed all 5 years ago*):______________________________
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____
____
____

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct, and I do not know of any existing physical or any additional health reasons that would preclude my participation in sport. I certify that the answers to the questions in the comprehensive review of this form are true and accurate. I consent to participation in all USS sanctioned activities. I hereby authorize release of this information contained in this document to the USS Sports Medicine Team. Upon written request, I may receive a copy of this document for my own personal health care records.

Signature of Athlete______________________________Date______________

Signature of Parent/Guardian (if a minor)______________________________Date______________

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INFORMATION BELOW IS COMPLETED BY SPORTS MEDICINE STAFF

Age_____________ Current Heart Rate ______________ bpm Current Blood Pressure_____________/___________ Corrected Vision ☐ Yes ☐ No

Height (inches)_______________ (cm)_____________Weight (pounds)______________ (kg)_____________Visual Acuity R 20/__________ L/20__________

Medical	Normal	Abnormal Findings
GENERAL APPERANCE (Marfan Syndrome)		
EYES / EARS / NOES / THROAT		
HEARING		
LYMPH NODES		
HEART (heart murmur)		
BLOOD VESSELS (radial and femoral pulses)		
BLOOD PRESSURE (brachial, various positions)		
LUNGS		
ABDOMEN/GROIN		
GENITOURINARY (males only)		
SKIN		
DENTAL		
NEUROLOGIC		
Orthopedic		
CERVICAL SPINE / NECK		
THORACIC / RIBS / BACK		
CHEST / RIBS		
SHOULDER / ARM		
ELBOW / FOREARM		
WRIST / HAND / FINGERS		
PELVIS / HIP / THIGH		
KNEE		
LOWER LEG		
ANKLE		
FOOT / TOES		
FUNCTIONAL (DL / SL squat, step drop test, etc)		

Blood Tests Requested ☐ No ☐ Yes (explain)____

Recommendations or additional concerns:____

____

CLEARED FOR ALL SPORT ACTIVITY ☐ **YES** ☐ **NO**

Not Cleared / Limited Clearance ☐ **Pending further evaluation** ☐ **For All Sport Activity** ☐ **On-Ice Training** ☐ **Dry land Training**

Treatment plan / Recommendations if not cleared for sport____

____

I have examined the above-named athlete and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and may participate in speedskating and all activities associated with said sport. If conditions arise after the athlete has been cleared for participation, the sports medicine team may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete or parent/guardian.

Name of Physician (print)______________________________________Date____________________

Signature of Physician_________________________________Signature of USS___________________________