2015 Ayrsley Town Blvd. Suite 200 | Charlotte, NC 28273
Phone: (704) 504-2400 | Fax: (980) 318-5296

Team Event
Medical History Form

This is a screening examination for participation in a physically challenging event. This does not substitute for a comprehensive examination with your regular physician where important preventative health information can be covered.

Do you have any health problems which may affect your full participation in the event (i.e. allergies, asthmas, arthritis, etc.)?

_____

Do you have any known food allergies? _____

Do you have any known drug allergies? _____

Do you have any known health conditions? _____

Do you currently take any medications? If so, what and how often?

_____

_____

Do you have any food restrictions (i.e. vegetarian, lactose intolerant, etc.)? _____

Emergency Contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Day Phone: _____ Evening Phone: _____

CONSENT TO MEDICAL CARE AND TREATMENT: The undersigned authorizes all medical, surgical, diagnostic and hospital procedures as may be performed or prescribed by a treating physician for the named participant. It is understood this authorization is given in advance of any specific diagnosis, treatment or hospital care being required. This authorization is in effect for the full duration of this event/project.

By signing below, I agree that I have reviewed and answered each question above completely and correctly to the best of my knowledge.

PARTICIPANT NAME (Print): _____ SIGNATURE: _____

What is your current level of physical activity?

_____

If you have had or are currently experiencing any of the following conditions, please circle the number and give details and the end of this section.

1. Any problems with vision or hearing, require glasses or hearing aid.
2. Dizzy spells, fainting, convulsions, persistent headache.
3. Frequent infection of throat, tonsils, sinuses, ears.
4. Chronic cough, bronchitis, bloody sputum.
5. Shortness of breath, or asthmas on exertion.
6. Chest pains on exertion or deep breathing.
7. Palpitation of the heart, irregular heartbeat, heart murmurs or poor circulation.
8. Low or high blood pressure.
9. Frequent nausea or vomiting, food intolerances, heartburn.
10. Jaundice or hepatitis.
11. Frequent diarrhea or blood in stools.
12. Frequent abdominal pain.
13. Hernia.
14. Difficulty urinating, burning or pain upon urination.
15. Kidney infection or stones.
16. Chronic pain in neck, back, shoulders, arms or legs.
17. Broken bones, join dislocations, serious sprains.
18. Joint pains, swelling or stiffness without injury.
19. Any severe injury to head, chest, internal organs.
20. Severe illness requiring hospitalization or prolonged incapacitation.
21. Chronic skin problems (rash or infection).
22. Reaction to extremes of temperature, frostbite, impaired circulation.
23. Claustrophobia, agoraphobia, acrophobia (strong fear of confined, open areas or heights).
24. Continuing use of alcohol, drugs or medications.
25. Episodes of depression, anxiety, hysteria, nervousness.
26. History of diabetes, thyroid trouble, bleeding problems.
27. Currently on any medication. If so, what?
28. Special dietary restrictions.
29. Hypoglycemia.
30. Allergy to any food, drug or other substance.
31. Under the treatment of a psychologist or psychiatrist.
32. Current of past drug-related problem.
33. Other: _____
    _____

2015 Ayrsley Town Blvd. Suite 200 | Charlotte, NC 28273
Phone: (704) 504-2400 | Fax: (980) 318-5296

If you circled any items, please list the details according to number. Be specific (include dates, names of medications, history of condition, etc.).

_____

_____

_____

Height: _____ Weight: _____ BP: _____ Pulse: _____

Physical Examination (Must be completed by a licensed Physician, Nurse Practitioner, or Physician's Assistant.

Date of Examination: _____

	NORMAL	ABNORMAL	ABNORMAL FINDINGS
HEART			
LUNGS			
SKIN			
HEENT			
ABDOMINAL			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			

Clearance:

____ Cleared

____ Cleared after completing _____.

____ Not cleared for _____.

Physician's Signature: _____ Date: _____

Physician's Office Stamp (Required):