

HEALTH MAINTENANCE/SPORTS EVALUATION (12 - 18 YEARS)

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974. USE BLANKET PAS, DD FORM 2005.)

1. DATE (YYYYMMDD)	2. PROVIDER	3. IMMUNIZATIONS <input type="checkbox"/> UTD <input type="checkbox"/> NOT UTD	4. PATIENT'S AGE YEARS	5. HEIGHT <input type="checkbox"/> INCH <input type="checkbox"/> CM
6. WEIGHT <input type="checkbox"/> LBS <input type="checkbox"/> KG	7. BLOOD PRESSURE	8. VISION a. RIGHT 20/ b. LEFT 20/		9. DRUG ALLERGIES

10. MEDICAL HISTORY

(Please answer the questions below YES or NO.
Explain any YES answers and list any concerns you wish to discuss in REMARKS below.)

	YES	NO		YES	NO
(1) Have you had a medical illness or injury since the last checkup?	<input type="checkbox"/>	<input type="checkbox"/>	(18) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
(2) Do you have an on-going or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	(19) Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
(3) Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	(20) Has a physician ever told you not to participate in sports?	<input type="checkbox"/>	<input type="checkbox"/>
(4) Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	(21) Do you have any skin problems (for example, itching, rashes or acne)?	<input type="checkbox"/>	<input type="checkbox"/>
(5) Have you ever broken any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>	(22) Do you have any problems with your eyes or vision ?	<input type="checkbox"/>	<input type="checkbox"/>
(6) Do you have any allergies (for example to pollen, medicine, food, or stinging insects) ?	<input type="checkbox"/>	<input type="checkbox"/>	(23) Do you wear glasses, contacts, or protective eye-wear?	<input type="checkbox"/>	<input type="checkbox"/>
(7) Have you ever been dizzy or passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	(24) Do you wear dental bridges or braces?	<input type="checkbox"/>	<input type="checkbox"/>
(8) Have you ever had a concussion or been unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	(25) Are you currently taking any medications? (Please list)	<input type="checkbox"/>	<input type="checkbox"/>
(9) Have you ever had racing of your heart or irregular heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	(26) Do you want to weigh more or less than you do?	<input type="checkbox"/>	<input type="checkbox"/>
(10) Have you ever had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	(27) Do you feel stressed or down? Have you ever felt like hurting yourself?	<input type="checkbox"/>	<input type="checkbox"/>
(11) Have you ever been told you have a heart murmur or heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	(28) Do you have trouble making or keeping friends?	<input type="checkbox"/>	<input type="checkbox"/>
(12) Has any family member died of heart problems or sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	(29) Do you have concerns about school or family?	<input type="checkbox"/>	<input type="checkbox"/>
(13) Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	(30) For Females: When was your first menstrual period?		
(14) Have you ever had an injury that required you to miss more than 2 days of practice or competition?	<input type="checkbox"/>	<input type="checkbox"/>	(31) For Females: In the last year, what is the longest time you have gone between menstrual periods?		
(15) Do you cough, wheeze or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	(32) Does anyone smoke or use tobacco in the family?	<input type="checkbox"/>	<input type="checkbox"/>
(16) Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	(33) Is there a family history of any of the following diseases? <input type="checkbox"/> Asthma <input type="checkbox"/> High cholesterol <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart disease <input type="checkbox"/> Stroke <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
(17) Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

(34) REMARKS (Explain any "YES" answers and concerns from above)

11. PATIENT'S NAME (Last, First, Middle Initial)	12. FMP	13. SSN
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14. OBJECTIVE

a. COMMENTS ON HISTORY/CONCERNS

b. NUTRITION

c. EXERCISE

d. SLEEP

e. BEHAVIOR ISSUES

15. PHYSICAL EXAMINATION		NORMAL EXAM (a)	ABNORMAL FINDINGS (b)	NOT EXAMINED (c)
(1) GENERAL:	Well developed, well nourished	<input type="checkbox"/>		<input type="checkbox"/>
(2) HEAD:	Normal shape and size	<input type="checkbox"/>		<input type="checkbox"/>
(3) EARS:	TMs clear and mobile	<input type="checkbox"/>		<input type="checkbox"/>
(4) EYES:	PERRLA, normal EOM, normal alignment	<input type="checkbox"/>		<input type="checkbox"/>
(5) NOSE:	Patent, no discharge, normal mucosa	<input type="checkbox"/>		<input type="checkbox"/>
(6) TEETH:	Normal alignment, no caries	<input type="checkbox"/>		<input type="checkbox"/>
(7) MOUTH:	Normal mucosa and tonsils	<input type="checkbox"/>		<input type="checkbox"/>
(8) NECK:	Supple, FROM, no masses, normal thyroid	<input type="checkbox"/>		<input type="checkbox"/>
(9) CHEST:	Unlabored respirations, clear to auscultation	<input type="checkbox"/>		<input type="checkbox"/>
(10) CV:	RRR, normal heart sounds, no murmur, normal pulses	<input type="checkbox"/>		<input type="checkbox"/>
(11) ABDOMEN:	Soft, nontender, no hepatosplenomegaly	<input type="checkbox"/>		<input type="checkbox"/>
(12) GENITALIA:	Tanner stage <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5			
a. FEMALE:	Normal external anatomy, no inguinal hernia	<input type="checkbox"/>		<input type="checkbox"/>
b. MALE:	Normal testicles and penis, no inguinal hernia	<input type="checkbox"/>		<input type="checkbox"/>
(13) RECTAL:	Normal external appearance	<input type="checkbox"/>		<input type="checkbox"/>
(14) MUSCULO-SKELETAL:	14-step screening	<input type="checkbox"/>		<input type="checkbox"/>
(15) SKIN:	No rash	<input type="checkbox"/>		<input type="checkbox"/>
(16) NEUROLOGICAL:	Normal tone, strength and reflexes	<input type="checkbox"/>		<input type="checkbox"/>

16. ASSESSMENT OF ABILITY TO PARTICIPATE IN SPORTS AND GENERAL HEALTH

HEALTHY CHILD - May participate in all sports Yes No

17. PLAN

a. ANTICIPATORY GUIDANCE (Check all that apply)

- | | | |
|--|---|---|
| (1) <input type="checkbox"/> Nutrition | (5) <input type="checkbox"/> Bike helmet | (9) <input type="checkbox"/> Alcohol, tobacco, other drug use |
| (2) <input type="checkbox"/> Adequate sleep | (8) <input type="checkbox"/> Water safety | (10) <input type="checkbox"/> Sexual activity |
| (3) <input type="checkbox"/> Dental care: routine exam, fluoride | (7) <input type="checkbox"/> Breast/testicular exam | (11) <input type="checkbox"/> Parental involvement |
| (4) <input type="checkbox"/> TV/Video viewing | (8) <input type="checkbox"/> Auto safety/seat belts | (12) <input type="checkbox"/> Other: _____ |

b. RECOMMENDATIONS

c. LABS: CBC U/A Other: _____

d. IMMUNIZATIONS: dT HepB MMR Other: _____

e. FOLLOW-UP: 14 years 15 years 16 years 17 years 18 years

18. PROVIDER'S SIGNATURE/STAMP