LIBERTY SPORTS MEDICINE PRE-PARTICIPATION PHYSICAL EVALUATION HEALTH QUESTIONNAIRE

NAME: _____ Sex: M/ F AGE: _____ DOB: ____/____/_____

Answer all questions and explain all "YES" answers below:

	Yes	No	
1.	☐	☐	Do you have an ongoing chronic illness? (i.e. diabetes, ADHD, etc.)
2.	☐	☐	Have you ever had surgery or been hospitalized overnight?
3.	☐	☐	Are you currently taking any prescription or nonprescription medications? (i.e. inhalers, supplements or birth control)
4.	☐	☐	Have you ever taken supplements to lose or gain weight or improve your performance?
5.	☐	☐	Have you ever been told you have sickle cell or sickle cell trait?
6.	☐	☐	Do you have any allergies? (i.e. pollen, medicine, foods or stinging insects)
7.	☐	☐	Have you ever had a rash or hives develop during exercise?
8.	☐	☐	Have you ever been dizzy, passed out, or had chest pains during or after exercise?
9.	☐	☐	Do you get tired more quickly than your friends do during exercise?
10.	☐	☐	Have you ever had racing of your heart or skipped heart beats?
11.	☐	☐	Have you had high blood pressure or high cholesterol?
12.	☐	☐	Have you ever been told you have a heart murmur?
13.	☐	☐	Has any family member or relative died of heart problems or of sudden death before the age of 50?
14.	☐	☐	Have you had a severe viral infection such as mononucleosis or myocarditis within the last six months?
15.	☐	☐	Has a physician ever denied or restricted your participation in sports for any heart problems?
16.	☐	☐	Do you have any current skin problems? (i.e. itching, rash, warts, fungus, blisters, etc.)
17.	☐	☐	Have you ever had a head injury or concussion?
18.	☐	☐	Have you ever been knocked out, became unconscious or lost your memory?
19.	☐	☐	Have you ever had a seizure?
20.	☐	☐	Do you have frequent or severe headaches?
21.	☐	☐	Have you ever had numbness or tingling in your arms, hands, legs or feet?
22.	☐	☐	Have you ever had a stinger, burner or pinched nerve
23.	☐	☐	Have you ever become ill from exercise in the heat?
24.	☐	☐	Do you have asthma?
25.	☐	☐	Do you cough, wheeze or have trouble breathing during or after activity?
26.	☐	☐	Do you have seasonal allergies that require medical attention?
27.	☐	☐	Do you use any special protective or corrective equipment that are not currently used for your sport?
28.	☐	☐	Do you have any problems with your eyes or vision?
29.	☐	☐	Do you wear glasses, contacts, or protective eyewear?
30.	☐	☐	Have you ever had a sprain, strain, or swelling after injury?
31.	☐	☐	Have you ever fractured any bones or dislocated any joints?
32	☐	☐	Have you had any problems with pain or swelling in muscles, tendons, bones, or joints? Circle all that apply:
			•Head / Neck / Back •Shoulder / Upper Arm •Ankle / Foot •Knee •Chest
			•Elbow / Forearm •Hand / Finger •Hip / Thigh • Shin / Calf •Wrist
33.	☐	☐	Do you want to weigh more or less than you do right now?

Females: How many periods have you had in the last year? ____ When was your most recent menstrual period? _____

EXPLAIN ALL "YES" ANSWERS HERE:_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete _____ Date: _____

Liberty University
Pre-Participation Physical Evaluation

PHYSICAL EXAMINATION

Name _____ Date of birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____/_____ (_____/_____, _____/_____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	Initials*
MEDICAL			
Appearance			
Eye/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*station-based examination only

CLEARANCE

O **Cleared**

O **Cleared after completing evaluation/rehabilitation for**: _____

_____

O **Not cleared for**: _____ **Reason**: _____

Recommendations: _____

_____

_____

_____

_____

Name of physician (print/type) _____ **Date** _____

Address _____

Signature of physician _____, MD