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**

<table>
<thead>
<tr>
<th>Name __________________________________________</th>
<th>Date of birth ___________________ ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height ____________</td>
<td>Weight ____________</td>
</tr>
<tr>
<td>Vision R 20/_____</td>
<td>L 20/_____</td>
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</tbody>
</table>

**NORMAL**

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>ABNORMAL FINDINGS</th>
<th>Initials*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye/Ears/Nose/Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia (males only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MUSCULOSKELETAL**

<table>
<thead>
<tr>
<th>Neck</th>
<th>Back</th>
<th>Shoulder/arm</th>
<th>Elbow/forearm</th>
<th>Wrist/hand</th>
<th>Hip/thigh</th>
<th>Knee</th>
<th>Leg/ankle</th>
<th>Foot</th>
</tr>
</thead>
</table>

*station-based examination only

**CLEARANCE**

- [ ] Cleared
- [ ] Cleared after completing evaluation/rehabilitation for: __________________________________________
  __________________________________________

- [ ] Not cleared for: __________________________________________ __ Reason: __________________________________________________________________________

  Recommendations: __________________________________________________________________________
  __________________________________________________________________________
  __________________________________________________________________________
  __________________________________________________________________________
  __________________________________________________________________________

Name of physician (print/type) __________________________________________ Date __________________________

Address __________________________________________

Signature of physician __________________________________________, MD