

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician

Part I -- Medical History - Explain "Yes" answers

This form must be completed and signed, prior to the physical examination, for review by examining practitioner. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY		Yes	No	MEDICAL QUESTIONS (cont)		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?				29. Do you have groin pain or a painful bulge or hernia in the groin area?			
2. Do you currently have an ongoing medical condition? If so, please identify:				30. Have you had mononucleosis (mono) within the last month?			
3. Have you ever spent the night in the hospital?				31. Do you have any shingles, pressure sores, or other skin problems?			
4. Have you ever had surgery?				32. Have you ever had a herpes or MRSA skin infection?			
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	33. Are you currently taking any medication on a daily basis?			
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?				34. Have you ever had a head injury or concussion? How many concussions: _____ Most recent concussion: _____			
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?				35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
7. Does your heart race or skip beats during exercise?				36. Do you have headaches with exercise?			
8. Has a doctor ever told you that you have (check all that apply): High Blood Pressure A Heart Murmur High Cholesterol A Heart Infection Kawasaki Disease Other:				37. Have you ever been unable to move your arms or legs after being hit or falling?			
9. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)				38. When exercising in heat, do you have severe muscle cramps or become ill?			
10. Do you get lightheaded or feel more short of breath than expected during exercise?				39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?			
11. Have you ever had an unexplained seizure?				40. Have you had any other blood disorders?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No	41. Have you had any problems with your eyes or vision?			
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?				42. Do you wear glasses or contact lenses?			
13. Does anyone in your family have a heart problem				43. Do you wear protective eyewear, such as goggles or a face shield?			
14. Does any one in your family have a pacemaker or implanted defibrillator?				44. Do you worry about your weight?			
15. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?				45. Are you trying to or has any professional recommended that you try to gain or lose weight?			
16. Do you regularly use a brace or assistive device?				46. Do you limit or carefully control what you eat?			
BONE AND JOINT QUESTIONS				47. Do you have any concerns that you would like to discuss with a doctor?			
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?				48. What is the date of your last Tdap or Td(tetanus) immunization? (Circle type) Date: _____			
18. Have you had any broken or fractured bones or dislocated joints?				49. Do you have an allergy to medicine, food or stinging insects?			
19. Have you had a bone injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches?				FEMALES ONLY			
20. Have you ever had an x-ray on your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?				50. Have you ever had a menstrual period?			
21. Have you ever had a stress fracture of a bone?				51. Age when you had your first menstrual period? _____			
22. Do you regularly use a brace or assistive device?				52. How many periods have you had in the last 12 months? _____			
23. Do you currently have a bone, muscle, or joint injury that bothers you?				EXPLAIN "YES" ANSWERS BELOW:			
24. Do any of your joints become painful, swollen, feel warm, or look red?				# _____ -> _____			
25. Do you have a history of juvenile arthritis or connective tissue disease?				# _____ -> _____			
MEDICAL QUESTIONS				# _____ -> _____			
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?				# _____ -> _____			
27. Do you have asthma or use asthma medicine (inhaler, nebulizer)?				# _____ -> _____			
28. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?				*List medications and nutritional supplements you are currently taking here:			

Athlete's Signature: _____ Date: _____ (IF UNDER 18) Parent/Guardian Signature: _____

PART II -- PHYSICAL EXAMINATION

(Physical examination form is required for Freshman and Transfer students before the first semester of participation and is good through the remaining years as a Club Sport athlete)

Name _____	Date of Birth _____	Year _____
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____	Resting Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected: Y/N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		
MUSKULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		

Medical Practitioner to Club Sports AT's (please indicate any instructions or recommendations here)	
Emergency medications required on-site _____	<input type="checkbox"/> Inhaler <input type="checkbox"/> Epinephrine <input type="checkbox"/> Glucagon <input type="checkbox"/> Other: _____
Comments: _____	History of Concussions: _____ Number of Concussions: _____ Most Recent Concussion: _____

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- CLEARED WITHOUT RESTRICTIONS**
- CLEARED WITH FOLLOWING NOTATION:** _____
- Cleared **AFTER** documented further evaluation or treatment for: _____
- Cleared for **Limited participation** (check and explain "reasons" for all that apply): "*Limited Until Date*" when appropriate
 - Not cleared for (specific sports) _____ Until Date: _____
- NOT CLEARED FOR PARTICIPATION Reason** _____

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Part I - Medical History.

Physician Signature: _____ (+MD, DO, LNP, PA). Date** _____

Examiner's Name and degree (print): _____ Phone Number _____

Address: _____ City _____ State _____ Zip _____

Only signatures of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.