Name: _____ Sport: _____ Year: _____

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
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you currently have an ongoing medical condition? If so, please identify:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
7. Does your heart race or skip beats during 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:		
9. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)?		
13. Does anyone in your family have a heart problem?		
14. Does anyone in your family have a pacemaker or implanted defibrillator?		
15. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?		
16. Do you regularly use a brace or assistive device?		
BONE AND JOINT QUESTIONS		
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?		
18. Have you had any broken or fractured bones or dislocated joints?		
19. Have you had a bone injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches?		
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?		
21. Have you ever had a stress fracture of a bone?		
22. Do you regularly use a brace or assistive device?		
23. Do you currently have a bone, muscle, or joint injury that bothers you?		
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?		

MEDICAL QUESTIONS (cont.)	Yes	No
29. Do you have groin pain or a painful bulge or hernia in the groin area?		
30. Have you had mononucleosis (mono) within the last month?		
31. Do you have any ashes pressure sores, or other skin problems?		
32. Have you ever had a herpes or MRSA skin infection?		
33. Are you currently taking any medication on a daily basis?		
34. Have you ever had a head injury or concussion? How many concussions: ____ Most recent concussion: _____		
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36. Do you have headaches with exercise?		
37. Have you ever been unable to move your arms or legs after being hit or falling?		
38. When exercising in heat, do you have severe muscle cramps or become ill?		
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
40. Have you had any other blood disorders?		
41. Have you had any problems with our eyes or vision?		
42. Do you wear glasses or contact lenses?		
43. Do you wear protective eyewear, such as goggles or a face shield?		
44. Do you worry about your weight?		
45. Are you trying to or has any professional recommended that you try to gain or lose weight?		
46. Do you limit or carefully control what you eat?		
47. Do you have any concerns that you would like to discuss with a doctor?		
48. What is the date of your last T-dap or Td (tetanus) immunization? (Circle type) Date: _____		
49. Do you have an allergy to medicine, food or stinging insects?		
FEMALES ONLY 50. Have you ever had a menstrual period?		
51. Age when you had your first menstrual period? _____		
52. How many periods have you had in the last 12 months? _____		
EXPLAIN "YES" ANSWERS BELOW: #____ ->_____ #____ ->_____ #____ ->_____ #____ ->_____ #____ ->_____ ***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_____ **DOB** _____ **Team** _____ **Year** _____

Height	Weight	☐ Male	☐ 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	☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ 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.