ATHLETE NAME(print legibly):_____**SPORT:**_____

SPORTS MEDICINE INITIAL PRE-PARTICIPATION EXAMINATION FORM

Family History

1. Has anyone in your family ever had diabetes (high blood sugar)? Yes ☐ No ☐
2. Has anyone in your immediate family ever had sudden death (age less than 50)? Yes ☐ No ☐
3. Has anyone in your immediate family ever had high blood pressure or high cholesterol? Yes ☐ No ☐
4. Has anyone in your immediate family ever had a heart attack (age less than 50)? Yes ☐ No ☐
5. Has anyone in your immediate family ever had asthma? Yes ☐ No ☐
6. Does anyone in your immediate family or sick cell anemia? Yes ☐ No ☐
7. Has anyone in your immediate family ever had convulsions (seizures) or epilepsy? Yes ☐ No ☐
8. Has anyone in your immediate family ever had hypertophic cardiomyopathy, Long QT syndrome, Marfans, or arrhythmias? Yes ☐ No ☐

If you said yes to any of the above questions (1-7), please explain: _____

_____

Personal Medical History

9. Have you ever had or do you now have chest pain with or after exercise? Yes ☐ No ☐
10. Have you ever had or do you now have dizziness or headaches with or after exercise? Yes ☐ No ☐
11. Have you ever had or do you now have high blood pressure? Yes ☐ No ☐
12. Have you ever had or do you now have racing of the heart/irregular rhythm? Yes ☐ No ☐
13. Have you ever had or do you now have wheezing/cough with exercise, or asthma? Yes ☐ No ☐
14. Have you ever had or do you now have a heart murmur? Yes ☐ No ☐
15. Have you ever had or do you now have weakness, fatigue, or anemia? Yes ☐ No ☐
16. Have you had or do you now have hearing loss or perforated eardrum? Yes ☐ No ☐
17. Have you had or do you now have dental plate or orthodontic work? Yes ☐ No ☐
18. Have you had or do you now have impaired vision, wear glasses/contacts? Yes ☐ No ☐
19. Have you had or do you now have a hernia? Yes ☐ No ☐
20. Have you had or do you now have kidney disease or damage? Yes ☐ No ☐
21. Have you had or do you now have a single kidney/eye/testicle or any other paired organ? Yes ☐ No ☐
22. Do you have migraines or headaches? Yes ☐ No ☐
23. Has a physician ever denied or restricted you from play? Yes ☐ No ☐
24. Have you ever had an echo? Yes ☐ No ☐
25. Have you ever lost consciousness? Yes ☐ No ☐
26. Have you ever been hit in the head with loss of consciousness or amnesia after? Yes ☐ No ☐
27. Have you ever had a concussion or traumatic brain injury (bell ring/ding)? Yes ☐ No ☐
28. Have you ever had a “stinger”, “burner”, or “pinched nerve”? Yes ☐ No ☐
29. Have you ever had convulsions (seizures) or epilepsy? Yes ☐ No ☐
30. Have you ever had a neck injury? Yes ☐ No ☐
31. Have you ever been hospitalized for a medical problem? Yes ☐ No ☐
32. Have you ever had infectious mononucleosis? Yes ☐ No ☐
33. Have you ever had heat exhaustion or intolerance? Yes ☐ No ☐
34. Have you ever been hospitalized or had surgery? Yes ☐ No ☐
35. Have you ever had or do you now have depression or anxiety? Yes ☐ No ☐
36. Have you ever had or do you now have thoughts about or attempted suicide? Yes ☐ No ☐

If you said yes to any of the above questions (8-36), please explain: _____

_____

Musculoskeletal Injuries

37. Have you ever broken a bone? Yes ☐ No ☐
38. Have you ever had a stress fracture? Yes ☐ No ☐
39. Have you ever had a muscle injury? Yes ☐ No ☐
40. Have you ever had a knee injury? Yes ☐ No ☐
41. Have you ever had a shoulder injury? Yes ☐ No ☐
42. Have you ever had a back injury? Yes ☐ No ☐
43. Have you ever seen a chiropractor? Yes ☐ No ☐
44. Have you ever had a foot injury? Yes ☐ No ☐
45. Have you ever had an ankle injury? Yes ☐ No ☐
46. Have you ever injured a joint not listed above? Yes ☐ No ☐

If you said yes to any of the above questions (37-46), please explain: _____

_____

Medication and Allergies

47. Are you currently taking any medications (this includes **vitamins, over the counter medications**, **supplements, and birth control pills**)? Yes ☐ No ☐
    If yes, please list: _____
48. Are you allergic to any medications? Yes ☐ No ☐
    If yes, please list: _____
49. Do you have any other allergies? Yes ☐ No ☐
    If yes, please list: _____

Immunization History

50. Please attach a copy of your current immunizations.

Females Only

51. At what age did you have your first menstrual cycle? _____
52. How many days do you have menstrual bleeding? _____
53. Typically, how many days is your menstrual cycle? _____
54. How many periods have you had in the past 12 months? _____
55. Have you ever had cramping with your period that required treatment? Yes ☐ No ☐
56. Have you ever had irregular cycles? Yes ☐ No ☐
57. Have you ever had heavy bleeding? Yes ☐ No ☐
58. Have you ever had a PAP or pelvic exam? Yes ☐ No ☐
59. If so, have you ever had an ABNORMAL pelvic exam or PAP smear? Yes ☐ No ☐
60. Are you currently taking oral contraceptives or hormones? Yes ☐ No ☐
61. What is the primary reason you are currently taking oral contraceptives or hormones? _____
62. Has a physician ever told you that you had anemia (low hematocrit or iron)? Yes ☐ No ☐

If you said yes to any of the above questions (51-62), please explain: _____

_____

Background Information

63. What is your current year in college? (please circle): 1 2 3 4 5 6 graduate student
64. What is your ethnic/racial group? (please circle):
    American Indian or Alaska Native Asian Black or African American Hispanic or Latino
    Native Hawaiian or other Pacific Islander White Other: _____

Health Habits

65. Have you in the past or do you currently use cigarettes, chewing tobacco, or other tobacco products? Yes ☐ No ☐
66. Have you in the past or do you currently use marijuana/Spice/THC? Yes ☐ No ☐
67. Have you in the past or do you currently use amphetamines/stimulants? Yes ☐ No ☐
68. Have you in the past or do you currently use other recreational drugs? Yes ☐ No ☐
69. Have you in the past or are you currently being treated for a drug problem? Yes ☐ No ☐
70. Do you have any drug-related concerns that you would like to discuss with a medical professional? Yes ☐ No ☐
71. Do you have concerns about family members with drug use/abuse problems? Yes ☐ No ☐

72. Have you in the past or do you currently use steroids? Yes ☐ No ☐
73. Have you in the past or do you currently use alcohol? Yes ☐ No ☐
74. If so, how often? _____
75. Have you in the past or are you currently being treated for an alcohol problem? Yes ☐ No ☐
76. Do you have any alcohol-related concerns that you would like to discuss with a medical professional? Yes ☐ No ☐
77. Are you sexually active? Yes ☐ No ☐
78. Do you have a history of more than 2 sexual partners in the last 6 months? Yes ☐ No ☐
79. Do you have a history of any sexually transmitted disease? Yes ☐ No ☐
80. Do you have any questions or concerns about HIV? Yes ☐ No ☐

If you said yes to any of the above questions (65-80), please explain: _____
_____

Nutrition

81. Are you happy with your present weight? Yes ☐ No ☐
82. If you are not happy with your present weight, do you have concerns? Yes ☐ No ☐
83. If you are not happy with your present weight, what is your desired weight in pounds? _____
84. Does weight affect the way you feel about yourself? Yes ☐ No ☐
85. Do you ever eat in secret? Yes ☐ No ☐
86. Do you worry that you have lost control over how much you eat? Yes ☐ No ☐
87. Do you try to lose weight to meet weight or image/appearance requirements for your sport? Yes ☐ No ☐
88. Have you ever tried to control your weight by excessive exercise? Yes ☐ No ☐
89. Have you ever tried to control your weight by vomiting? Yes ☐ No ☐
90. Have you ever tried to control your weight by using diet pills? Yes ☐ No ☐
91. Have you ever tried to control your weight by using laxatives or diuretics? Yes ☐ No ☐
92. Have you ever tried to control your weight by dieting/fasting? Yes ☐ No ☐
93. Have you ever had an eating disorder? Yes ☐ No ☐

If you said yes to any of the above questions (81-93), please explain: _____
_____

Honesty Waiver

I declare that all of the above information is true to the best of my knowledge.

Recognizing that my true physical condition is dependent on an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in this questionnaire any knowledge of my condition in my answers.

_____
Signature Date

COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

Student's Name: _____ Age: _____ Date of Birth: _____/____/_____
Sport(s): _____
Height: _____ Weight: _____ Brachial Artery BP: _____/_____ (_____/_____, _____/_____) RP: _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan Syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the Health History, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's Health History, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student:

☐ CLEARED
☐ CLEARED, with recommendation(s) for further evaluation or treatment for: _____
☐ NOT CLEARED, for the following types of sports (please check those that apply):
☐ Collision ☐ Contact ☐ Non-Contact ☐ Strenuous ☐ Moderately Strenuous ☐ Non-Strenuous
Due to: _____
Recommendation(s)/Referral(s): _____

Medical Professional's Name (print): _____

Medical Professional's Signature: _____ ☐ MD, ☐ DO, ☐ PAC, ☐ CRNP

Date _____