Preparticipation Physical Evaluation

History Form

Date of Exam ________________________________________________________________
Name _______________________________________________________________________
Sex_________  Age________  Sport(s)______________________________________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking. ______________________________________________________________

Do you have any Allergies? □ yes □ no  If yes, please identify specific allergy below:
________________________________________________________________________________________
________________________________________________________________________________________

Explain “yes” answers below. Circle questions you don’t know the answers to.

General Questions

1. Has a doctor ever denied or restricted your participation in sports for any reason? □ □
2. Do you have any ongoing medical conditions? If so, please identify below:
   □ Asthma  □ Anemia  □ Diabetes  □ Infections  □ Sickle cell  □ Heart Disease
   Other:______________________________________________________________ □ □
3. Have you ever spent the night in the hospital? □ □
4. Have you ever had surgery? □ □
5. Have you ever passed out or nearly passed out DURING or AFTER exercise? □ □
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? □ □
7. Does your heart ever race or skip beats (irregular beats during exercise)? □ □
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
   □ High blood pressure  □ High cholesterol  □ Kawasaki disease  □ A heart murmur
   □ A heart infection  □ Other:______________________________________________ □ □
9. Has a doctor ever ordered a test for your heart? (For example, 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? □ □
12. Do you get more tired or short of breath more quickly than your friends during exercise? □ □

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? □ □
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? □ □
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? □ □
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? □ □
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? □ □
18. Have you ever had any broken or fractured bones or dislocated joints? □ □
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? □ □
20. Have you ever had a stress fracture? □ □
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) □ □
22. Do you regularly use a brace, orthotics, or other assistive device? □ □
23. Do you 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 any history of juvenile arthritis or connective tissue disease? □ □
26. Do you cough, wheeze, or have difficulty breathing during or after exercise? □ □
27. Have you ever used an inhaler or taken asthma medicine? □ □
28. Is there anyone in your family who has asthma? □ □
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? □ □
30. Do you have groin pain or a painful bulge or hernia in the groin area? □ □
31. Have you had infectious mononucleosis (mono) within the last month? □ □
32. Do you have any rashes, pressure sores, or other skin problems? □ □
33. Have you had a herpes or MRSA skin infection? □ □
34. Have you ever had a head injury or concussion? □ □
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? □ □
36. Do you have a history of seizure disorder? □ □
37. Do you have headaches with exercise? □ □
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? □ □
39. Have you ever been unable to move your arms or legs after being hit or falling? □ □
40. Have you ever become ill while exercising in the heat? □ □
41. Do you get frequent muscle cramps when exercising? □ □
42. Have you or someone in your family have sickle cell trait or disease? □ □
43. Have you had any problems with your eyes or vision? □ □
44. Have you had any eye injuries? □ □
45. Do you wear glasses or contact lenses? □ □
46. Do you wear protective eyewear, such as goggles or a face shield? □ □
47. Do you worry about your weight? □ □
48. Are you trying to or has anyone recommended that you gain or lose weight? □ □
49. Are you on a special diet or do you avoid certain types of foods? □ □
50. Have you ever had an eating disorder? □ □
51. Do you have any concerns that you would like to discuss with a doctor? □ □
52. Have you ever had a menstrual period? If so date of last period.
53. How old were you when you had your first menstrual period?
54. How many periods have you had in the last 12 months?

Explain “yes” answers here
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Please read this section carefully

The undersigned athlete, herewith,
1. Understands that s/he must refrain from practice or play during medical treatment until s/he is discharged from treatment or given a written permit by the medical provider to resume participation.
2. Certifies that the answers to these questions are correct and true.
3. Understands that having passed the physical examination does not necessarily mean that s/he is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.
4. Fully realizes that SUNY Cobleskill cannot be held responsible for any previous medical condition(s) that s/he might have.
5. I give consent for the release of medical records pertaining to the participation in SUNY Cobleskill’s intercollegiate athletic program to the Certified Athletic Trainer. This includes the pre-entrance Health & Immunization Record, treatment notes, diagnostic tests and treatment plans related to sports injuries as prescribed by the Wellness Center.

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

Signature of athlete
___________________________________________________________________________________________

Signature of parent/guardian _______________________________________________ Date: __________________________