# Sierra College

## Preparticipation Physical Evaluation History

| | |
|---|---|
| **Name:** | **( ) Male ( ) Female** |
| **Sport:** | **Date of Birth _____/_____/_____ Age _____** |
| **Address:** | **City, Zip:** |
| **Home Phone #:** | **Cell Phone #:** |

**Medications: List all prescription and non-prescription medications you are taking:**

**Allergies: List any allergies you have (medications, pollens, stinging insects, food, etc.):**

**Supplements: List all vitamins and supplements you are taking:**

**Surgeries: List any operations you have had including dates:**

**Hospitalizations: List all hospital visits where you have spent the night in the hospital:**

**List all ongoing health problems (diabetes, asthma, epilepsy, depression/anxeity, anemia, infections, etc.):**

**Family History: Has anyone in your immediate family (Mother, Father, Brother, Sister) had any of the following?**

| Mark Yes or No | Yes | No | Mark Yes or No | Yes | No |
|---|---|---|---|---|---|
| Sudden death due to heart conditions or before age 50 | | | Pacemaker or implanted defibrillator | | |
| Heart conditions | | | Unexplained fainting or seizures | | |
| Hypertrophic Cardiomyopathy or Marfan Syndrome | | | Asthma | | |
| High blood pressure | | | Sickle cell trait or disease | | |

| Answer each of the following questions. | Yes | No | Explain all "Yes" answers |
|---|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | | |
| 2. Were you born without or are you missing a kidney, an eye, testicle (male), your spleen or any other organ? | | | |
| 3. When exercising in the heat, have you ever become ill or frequently get muscle cramps? | | | |
| 4. Do you or someone in your family have sickle cell trait or disease? | | | |
| 5. Have you had infectious mononucleosis (mono) within the last month? | | | |
| 6. Do you have pain in your groin or a painful bulge or hernia? | | | |
| **Cardiovascular** | | | |
| 7. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | | |
| 8. Have you ever had severe discomfort, pain, tightness or pressure in your chest during exercise? | | | |
| 9. Does your heart ever race or skip beats during exercise? | | | |
| 10. Has a doctor ever told you that you have (check any that apply)<br>High blood pressure Heart murmur<br>High cholesterol Heart infection<br>Other heart condition _____ | | | |
| 11. Do you get lightheaded or feel more tired or shortness of breath than you expected or than your friends during exercise? | | | |
| 12. Have you ever had an unexplained seizure? | | | |
| 13. Has a doctor ever ordered a test for your heart? | | | |
| **Respiratory** | | | |
| 14. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | | |
| 15. Have you ever used an inhaler or taken asthma medicine? | | | |

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**Name of Athlete:** _____

| **Dermatologic** | **Yes** | **No** | **Explain all "Yes" answers** |
|---|---|---|---|
| 16. Do you have any rashes, pressure sores, or other skin problems? | | | |
| 17. Have you had a herpes or MRSA skin infection? | | | |
| **Neurological** | | | |
| 18. Have you ever had a head injury or concussion? If so, how many and how long to recover from each one? | | | |
| 19. Have you had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | | |
| 20. Do you have migrane headaches or headaches with exercise? | | | |
| 21. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | | |
| 22. Have you ever been unable to move your arms or legs after being hit or falling? | | | |
| 23. Do you have a history of seizure disorder? | | | |
| **Ophthalmology** | | | |
| 24. Have you had an eye injury or any problems with your eyes or vision? | | | |
| 25. Do you wear glasses, contact lenses or protective eyewear, such as goggles or a face shield? | | | |
| **Musculoskeletal** | | | |
| 26. Have you ever had a significant injury to a bone, muscle, ligament, or tendon? **If so, body part and type of injury?** | | | |
| 27. Have you had injuries that caused you to miss a practice or a game? | | | |
| 28. Have you had any broken bones or dislocated joints? | | | |
| 29. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches? | | | |
| 30. Have you ever had a stress fracture? | | | |
| 31. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? | | | |
| 32. Do you regularly use a brace, orthotics or assistive device? | | | |
| 33. Do you have any bone, muscle or joint injuries that are currently bother you? | | | |

| | **Yes** | **No** |
|---|---|---|
| 34. Do you feel stressed out or under a lot of pressure? | | |
| 35. Do you ever feel sad, hopeless, depressed or anxious? | | |
| 36. Do you feel safe? | | |
| 37. Have you ever used cigarettes, chewing tobacco, snuff, or dip? | | |
| 38. During the past 30 days, did you use chewing tobacco, snuff, or dip? | | |
| 39. Do you drink alcohol or use any other drugs? | | |
| 40. Have you ever taken any supplements to help you gain or lose weight to improve your performance? | | |
| 41. Have you ever taken steroid pills or shots without a doctor's prescription? | | |
| 42. Do you worry about your weight? | | |
| 43. Are you trying to or has anyone recommended that you gain or lose weight? ( ) gain or ( ) lose | | |
| 44. Have you ever had an eating disorder? | | |
| 45. Do you have anything you would like to discuss with the provider? | | |

| **FEMALES ONLY:** | **Yes** | **No** |
|---|---|---|
| 46. How old were you when you had your first menstrual period? Age _____ | | |
| 47. Have you ever had an absence of periods or irregular menstrual cycle? | | |

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

**Signature:**_____ **Date:**_____

**Signature of parent / guardian (if athlete under 18 years):** _____ **Date:** _____

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## Preparticipation Physical Evaluation

**Name of Athlete:** _____

Height_____'_____" Weight_____lbs Pulse_____ BP_____/_____

Vision: R 20/_____ L 20/_____ Corrected: Yes_____ No_____ Pupils: Equal_____ Unequal_____

| Medical | Normal | Abnormal / Comments |
|---|---|---|
| Appearance | | |
| Eyes / Ears / Nose / Throat | | |
| Hearing | | |
| Lymph Nodes | | |
| Heart | | |
| Pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only) | | |
| Skin | | |
| Neurologic | | |
| **Musculoskeletal** | | |
| Neck | | |
| Back | | |
| Shoulders / Arms | | |
| Elbows / Forearms | | |
| Wrists / Hands / Fingers | | |
| Hips / Thighs | | |
| Knees | | |
| Legs / Ankles | | |
| Feet / Toes | | |

Notes: _____

## Clearance

☐ **Cleared without restriction**

☐ Cleared **with recommendations** for further evaluation or treatment for: _____

_____

☐ Cleared **after evaluation of:** _____

_____

☐ **Not cleared**

Reason_____

Recommendations_____

**Provider Name**_____ **Provider Signature**_____ **Date**_____

## Clinic Stamp: