

## Erie Community College Preparticipation Physical Evaluation

Name (Last, First) \_\_\_\_\_ Date \_\_\_\_\_ Sport(s) \_\_\_\_\_

DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)

Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

### History

Yes No

- 1. Has a doctor ever denied or restricted your participation in sports for any reason?
- 2. Do you have an ongoing medical condition (i.e. diabetes or asthma)?
- 3. Are you taking any prescription or non-prescription (over the counter) medicines or pills?
- 4. Do you have allergies to medicines, pollens, foods, or stinging insects?
- 5. Have you ever passed out or nearly passed out DURING exercise?
- 6. Have you ever passed out or nearly passed out AFTER exercise?
- 7. Have you ever had discomfort, pain, or pressure, in your chest during exercise?
- 8. Does your heart race or skip beats during exercise?
- 9. Has your doctor ever told you that you have high blood pressure, high cholesterol, a heart murmur, or a heart infection?
- 10. Has a doctor ever ordered a test for your heart (i.e. ECG, echocardiogram)?
- 11. Has anyone in your family ever died for no apparent reason?
- 12. Does anyone in your family have a heart problem?
- 13. Has any family member or relative died of heart problems or of sudden death before age 50?
- 14. Does anyone on your family have Marfan syndrome?
- 15. Have you ever spent the night in a hospital?
- 16. Have you ever had surgery?
- 17. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
- 18. Do you regularly use a brace or assistive device?
- 19. Has a doctor ever told you that you have asthma or allergies?
- 20. Do you cough wheeze, or have difficulty breathing during or after exercise?
- 21. Is there anyone in your family that has asthma?
- 22. Have you ever used an inhaler or taken asthma medicine?
- 23. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
- 24. Have you had infectious mononucleosis (mono) within the last month?
- 25. Do you have rashes, pressure sores, or other skin problems?
- 26. Have you had a herpes skin infection?
- 27. Have you ever had a head injury or concussion? If yes how many? \_\_\_\_\_
- 28. Have you been hit in the head and been confused or lost your memory?
- 29. Have you ever had a seizure?
- 30. Do you have headaches with exercise?
- 31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
- 32. Have you ever been unable to move your arms or legs after being hit or falling?
- 33. When exercising in the heat, do you have sever muscle cramps or become ill?
- 34. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
- 35. Have you had any problems with your eyes or vision?
- 36. Do you wear protective eyewear, such as goggles or a face shield?
- 37. Are you happy with your weight?
- 38. Are you trying to gain or lose weight?
- 39. Has anyone recommended you change your weight or eating habits?
- 40. Do you limit or carefully control what you eat?
- 41. Do you have any concerns that you would like to discuss with a doctor?
- For the following, if YES, circle corresponding location below:**
- 42. Have you ever had an injury like a sprain, muscle or ligament tear that caused you to miss a practice or game?
- 43. Have you have had any broken or fractured bones or dislocated joints?
- 44. Have had a bone or joint injury that required x-ray, MRI, CT, surgery, injection, or physical therapy?

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

### Females Only

- 45. Have you ever had a menstrual period?      **Yes**                      **No**
- 46. How old were you when you had your first menstrual period? \_\_\_\_\_
- 47. How many periods have you had in the last 12 months? \_\_\_\_\_

**Explain all YES answers here:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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### Follow-Up Questions on More Sensitive Issues

Yes No

- 1. Do you feel stressed out or under a lot of pressure?
- 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
- 3. Do you feel safe?
- 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
- 5. During the past 30 days, have you used chewing tobacco, snuff, or dip?
- 6. During the past 30 days have you had at least one drink of alcohol?
- 7. Have you ever taken steroid pills or shots without a doctor's prescription?
- 8. Have you ever taken any supplements to help gain or loose weight or improve your performance?

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Genitourinary (males only)			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

**Notes:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Cleared without restriction**
- Cleared, with recommendations for further evaluation or treatment for:** \_\_\_\_\_
- NOT cleared for**     **All sports**     **Certain sports:** \_\_\_\_\_  
**Reason:** \_\_\_\_\_

**Name of physician (print/type):** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone** \_\_\_\_\_  
**Signature of physician** \_\_\_\_\_