

# ELON UNIVERSITY SPORTS MEDICINE PRE-PARTICIPATION PHYSICAL EXAMINATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Class: \_\_\_\_\_ List all Varsity Sports: \_\_\_\_\_

Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Date of Last Exam: \_\_\_\_\_ Email address: \_\_\_\_\_

Current Medications and Dosage; (including vitamins, supplements, over the counter medications, birth control pills) \_\_\_\_\_

Allergies to any Medication? Yes No If so, which one(s)? \_\_\_\_\_

Other Allergies? (food, pollen, animals, etc.) \_\_\_\_\_

**The following should be completed by the student athlete with help from the parent(s) only as necessary. The following questions are to be answered yes or no. Please check the appropriate box. Comment on all "yes" answers. (Include dates if possible). For any significant medical or orthopedic problems, please obtain medical records. This may limit delays in your clearance to participate.**

Has anyone in your immediate family ever had:

YES	NO	DATE	YES	NO	DATE
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____

## COMMENTS \_\_\_\_\_

Have you ever had or do you now have:

YES	NO	DATE	YES	NO	DATE
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____

## COMMENTS \_\_\_\_\_

Have you ever:

YES	NO	DATE	YES	NO	DATE
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____
( )	( )	_____	( )	( )	_____

## COMMENTS \_\_\_\_\_

Do you know your sickle cell status? ( ) Yes ( ) No ( ) Unsure

**For the following questions, please provide detailed information (use accessory sheet of paper if necessary), include medical records, and also state the amount of time loss related to each injury/condition. (Include dates if possible).**

YES NO

DATE

( ) ( ) Been hospitalized for a musculoskeletal problem or had surgery \_\_\_\_\_

( ) ( ) Broken a bone \_\_\_\_\_

( ) ( ) Had a muscle injury \_\_\_\_\_

( ) ( ) Had a knee injury? R ( ) L ( ) Ligament ( ) Meniscus ( ) Other ( ) \_\_\_\_\_

( ) ( ) If yes, did you have surgery? Result: \_\_\_\_\_

( ) ( ) Had a shoulder injury? R ( ) L ( )

( ) ( ) If yes, did you have surgery? Result: \_\_\_\_\_

( ) ( ) Had a back injury?

( ) ( ) If yes, did you have surgery? Result: \_\_\_\_\_

( ) ( ) Had any other joint injuries? Check appropriate box(es):

( ) Hip ( ) Elbow ( ) Wrist ( ) Foot ( ) Other: \_\_\_\_\_

( ) ( ) Had an MRI, CT scan, bone scan or other special study? If so, please specify when and why: \_\_\_\_\_

( ) ( ) Had a stress fracture? If yes, state location, method of diagnosis, and time loss \_\_\_\_\_

( ) ( ) Do you currently wear prescribed orthotics? If so, why? \_\_\_\_\_

( ) ( ) If you have had a musculoskeletal injury, have you recovered fully from this injury and returned to full participation?

DATE

\_\_\_\_\_

\_\_\_\_\_

***\*For any significant medical or orthopedic problems, please obtain medical records.***

Have you had or do you now have:

YES NO

DATE

YES NO

( ) ( ) Hearing loss or perforated eardrum \_\_\_\_\_ ( ) ( ) Headaches or migraines \_\_\_\_\_

( ) ( ) Hernia \_\_\_\_\_ ( ) ( ) Loss of function or absence of testicle (males), ovary

( ) ( ) Dental plate, impaired vision, (females) or other paired organ (eyes, etc): \_\_\_\_\_

wear glasses/contacts: \_\_\_\_\_

Have you in the past, or do you currently use, or have concerns about:

YES NO

YES NO

( ) ( ) Cigarettes, chewing tobacco, or marijuana ( ) ( ) Recreational drugs or steroids

Do you:

YES NO

( ) ( ) Feel down, depressed or helpless

( ) ( ) Wear a seat belt 90% of the time

( ) ( ) Understand and regularly perform a self-breast exam or self-testicular exam

( ) ( ) Have a history of any sexually transmitted disease

YES NO

( ) ( ) Have little interest or pleasure in doing things

( ) ( ) Wear a bicycle/motorcycle helmet

( ) ( ) Practice safe sex

( ) ( ) Have a history of > 2 sexual partners in the last 6 months

( ) ( ) Have any additional concerns or questions

Have you in the past or do you currently use alcohol? YES NO

Have you in the past or are you currently being treated for an alcohol problem? YES NO

If you drink alcohol, answer the following questions, selecting the option that comes closest to your answer:

How often do you have an alcoholic drink? Never Monthly 2-4 X / mo 2-3 X / wk 4 or > / week

How many alcoholic drinks do you have on a typical day? 0, 1, or 2 3 to 5 6 to 8 10 or more

How often do you have 4 or more drinks on 1 occasion? Never < monthly Monthly Weekly Daily or almost daily

How often in the last year have you found you are unable to stop drinking once you've started?

Never < monthly Monthly Weekly Daily or almost daily

How often in the last year have you failed to do what was normally expected of you because of drinking?

Never < monthly Monthly Weekly Daily or almost daily

How often in the last year have you needed a drink in the morning to get yourself going after a heavy night of drinking?

Never < monthly Monthly Weekly Daily or almost daily

How often during the last year have you felt guilty or been remorseful after drinking?

Never < monthly Monthly Weekly Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because of your drinking? Never < monthly Monthly Weekly Daily or almost daily

Have you or someone else been injured as a result of your drinking? No / Yes, but not in the last year Yes, in the last year

Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

No / Yes, but not in the last year \_\_\_\_\_ Yes, in the last year \_\_\_\_\_

### Nutritional concerns:

What is your present weight? \_\_\_\_\_ Are you happy with your present weight? YES NO If not, what is your desired weight? \_\_\_\_\_

How many meals do you eat each day? \_\_\_\_\_ Do you diet regularly? YES NO

Do you avoid certain food groups (carbohydrates, protein, meat, fats, salt, other)? YES NO Why? \_\_\_\_\_

Do you ever feel out of control of your eating patterns? \_\_\_\_\_

Have you tried to control your weight by: Excessive exercise? YES NO Dieting/Fasting? YES NO Vomiting? YES NO

Diet pills? YES NO Laxatives? YES NO Diuretics? YES NO

Have you ever had an eating disorder? \_\_\_\_\_

Have you ever taken supplements to help you gain or lose weight or improve your performance? YES NO

List any current medications: (include vitamins, List any allergies: (medications, animals, food, pollen) \_\_\_\_\_

Over the counter medications, supplements, and birth control pills) \_\_\_\_\_

I, (Print Full Name) \_\_\_\_\_ declare that all of the above information is true to the best of my knowledge. If at any point, whether voluntary or involuntary, I leave the athletic program, I understand that I have 30 days to notify the Sports Medicine Staff of any injury/illness related to participation of intercollegiate athletics. Failure to do so will void the secondary insurance coverage supplied by Elon University Athletics.

(Signature) \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of parent if < 18 yrs. Old) \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICAL EXAMINATION**

**(To be completed by Elon University Physician)**

Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ corrected Y / N Pupil size: equal/unequal

**Normal Abnormal Comments**

YES NO

( ) ( ) HEENT \_\_\_\_\_

( ) ( ) Thyroid \_\_\_\_\_

( ) ( ) Lymphatics \_\_\_\_\_

( ) ( ) Cardiac \_\_\_\_\_

( ) ( ) Lungs \_\_\_\_\_

( ) ( ) Skin \_\_\_\_\_

( ) ( ) Abdominal \_\_\_\_\_

( ) ( ) Genitalia Hernia? If Yes, when \_\_\_\_\_

( ) ( ) Musculoskeletal: \_\_\_\_\_

( ) ( ) Neck \_\_\_\_\_

( ) ( ) Shoulder \_\_\_\_\_

( ) ( ) Elbow \_\_\_\_\_

( ) ( ) Wrist/hand \_\_\_\_\_

( ) ( ) Back Scoliosis? If Yes, when \_\_\_\_\_

( ) ( ) Knee \_\_\_\_\_

( ) ( ) Ankle, foot \_\_\_\_\_

( ) ( ) Neurological \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

I certify that I have reviewed the history and examined the above athlete, and I recommend sports activity:

Clearance with no limitations: \_\_\_\_\_

Clearance pending further evaluation or testing: \_\_\_\_\_

Referral to: \_\_\_\_\_ prior to clearance.

Clearance with limitations: \_\_\_\_\_

Disqualification from competition: \_\_\_\_\_

Signature of Examining Physician \_\_\_\_\_ Date \_\_\_\_\_