ELON UNIVERSITY SPORTS MEDICINE PRE-PARTICIPATION PHYSICAL EXAMINATION

Name: ______________________________ Date: ______________ Sex: ______ Age: ________

Date of Birth: __________ Class: ______ List all Varsity Sports: ______________________________

Cell Phone: (______) ____________________ Date of Last Exam: ________ Email address: ______________________________

<u>The following should be completed by the student athlete with help from the parent(s) only as necessary</u>. 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
( ) ( ) Diabetes (high blood sugar)
( ) ( ) High blood pressure, high cholesterol
( ) ( ) Asthma
( ) ( ) Convulsions (seizures) or epilepsy

YES NO
( ) ( ) Sudden Death (age less than 50)
( ) ( ) Heart attack (age less than 50)
( ) ( ) Sickle cell anemia
( ) ( ) Hypertrophic cardiomyopathy, Long QT syndrome, Marfan's, or arrhythmias

COMMENTS______________________________

Have you ever had or do you now have:

YES NO
( ) ( ) Chest pain with or after exercise
( ) ( ) High blood pressure
( ) ( ) Wheezing/cough with exercise, or asthma
( ) ( ) Heart murmur
( ) ( ) History of one kidney or non-functioning kidney

YES NO
( ) ( ) Dizziness with or after exercise
( ) ( ) Racing of the heart/irregular rhythm
( ) ( ) Weakness, fatigue, or anemia
( ) ( ) Any heart testing such as echocardiogram, stress test, other: ____________________

COMMENTS______________________________

Have you ever:

YES NO
( ) ( ) Had loss of consciousness
( ) ( ) Had convulsions (seizures) or epilepsy
( ) ( ) Had a "Stinger", "burner", or "pinched nerve"
( ) ( ) Had heat exhaustion or intolerance in sports?
( ) ( ) Had infectious mononucleosis?
If yes, + blood test? Y / N

YES NO
( ) ( ) Had a concussion
( ) ( ) Had neck injury
( ) ( ) Been denied or restricted from participation
( ) ( ) Been hospitalized for a medical problem
( ) ( ) Had any infectious skin problems (ringworm, fever blisters, herpes)

COMMENTS______________________________

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.

YES NO
( ) ( ) 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?

____

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

Have you had or do you now have:

YES NO
( ) ( ) Hearing loss or perforated eardrum
( ) ( ) Hernia
( ) ( ) Dental plate, impaired vision, wear glasses/contacts: ______________________

YES NO
( ) ( ) Headaches or migraines
( ) ( ) Loss of function or absence of testicle (males), ovary (females) or other paired organ (eyes, etc):_____________
____

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

YES NO
( ) ( ) Cigarettes, chewing tobacco, or marijuana

YES NO
( ) ( ) 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) ____

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I, ____________________________________declare that all of the above information is true to the best of my knowledge.
PRINT

(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 _______________