CATAWBA COLLEGE SPORTS MEDICINE

Preparticipation Physical
Photocopies NOT Accepted

DATE COMPLETED: _____ SPORT: _____ ARE YOU ADOPTED? **YES** **NO**

NAME _____ DATE OF BIRTH _____ SEX (M / F) _____ BANNER ID _____

Explain "Yes" answers below. Circle questions you don't know the answer to.

		YES	NO
1	Has a doctor ever denied or restricted your participation in sports for any reason?	( )	( )
2	Are you currenly being treated by a physician for any reason?	( )	( )
3	Do you have any ongoing medical condition (like diabetes, asthma, or migraine headaches)?	( )	( )
4	Are you currently taking **any** prescription or nonprescription (over-the-counter) medicines, pills or supplements?	( )	( )
5	Do you have any allergies to medicines, pollens, foods, or stinging insects?	( )	( )
6	Have you ever passed out or nearly passed out DURING exercise?	( )	( )
7	Have you ever passed our or nearly passed out AFTER exercise?	( )	( )
8	Have you ever had discomfort, pain or pressure in your chest during exercise?	( )	( )
9	Does your heart race or skip beats during exercise?	( )	( )
10	Has a doctor ever told you that you have (check all that apply) ( ) High blood pressure ( ) A hear murmur ( ) High cholesterol ( ) A heart infection		
11	Has a doctor ordered a test for your heart (for example ECG, echocardiogram, or stress test)?	( )	( )
12	Has anyone in your family died of no apparent reason?	( )	( )
13	Does anyone in your family have a heart problem?	( )	( )
14	Has any family member or relative died of heart problems or of sudden death before age 50?	( )	( )
15	Does anyone in your family have Marfan syndrome?	( )	( )
16	Have you ever been hospitalized or had a major illness?	( )	( )
17	Have you ever had surgery?	( )	( )
18	Have you ever had an injury, like a sprain, muscle tear, ligament tear, or tendonitis? If yes, circle affected area below:	( )	( )
19	Have you ever had any broken or fractured bones or dislocated joints? If yes, circle the affected area below:	( )	( )
20	Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	( )	( )

R / L	Head / Face	Neck	Shoulder	Upper arm	Elbow
R / L	Forearm	Hand / Fingers	Chest	Back	Hip
R / L	Thigh	Knee	Calf / Shin	Ankle	Foot / Toes

21	Have you had a stress fracture?	( )	( )
22	Do you regularly use a brace or assistive device?	( )	( )
23	Have you ever had a herpes skin infection?	( )	( )
24	Have you ever had an MRSA infection?	( )	( )
25	Do you have any rashes, pressure sores, or other skin problems?	( )	( )
26	Do you cough, wheeze, or have difficulty breathing during or after exercise?	( )	( )
27	Is there anyone in your family who has asthma?	( )	( )
28	Has a doctor ever told you that you have asthma or allergies?	( )	( )
29	Have you ever used an inhaler or taken asthma medication?	( )	( )
30	Do you have/have you ever had: ( ) Pneumonia ( ) Infectious mononucleosis ( ) Diabetes ( ) Bleeding problems/Anemia ( ) A hernia ( ) Recurrent headaches ( ) Depression ( ) Anorexia/Bulimia/Eating Disorder		
31	Have you ever had a head injury or concussion?	( )	( )
32	Have you ever been hit in the head and been confused, disoriented, or lost your memory?	( )	( )
33	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	( )	( )
34	Have you ever been unable to move your arms or legs after being hit or falling?	( )	( )
35	Have you ever had a seizure?	( )	( )
36	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	( )	( )
37	When exercising in the heat, do you have severe muscle cramps, heat illness or pass out?	( )	( )
38	Has a doctor told you that you have sickle cell trait or sickle cell disease?	( )	( )
39	Do you have headaches with exercise?	( )	( )
40	Have you had any problems with your eyes or vision?	( )	( )
41	Do you wear glasses or contacts?	( )	( )
42	Do you wear protective eyewear, such as goggles?	( )	( )
43	Are you happy with your weight?	( )	( )
44	Are you trying to lose or gain weight?	( )	( )
45	What is your ideal weight?		
46	Do you limit or carefully control what you eat?	( )	( )
47	Do you feel safe?	( )	( )
48	Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	( )	( )
49	Do you feel stressed out, anxious, nervous, or under a lot of pressure?	( )	( )
50	Are you using any performance enhancing substances or drugs?	( )	( )
51	When was your last Tetanus (dT) booster shot? Date:		
52	Do you have any concerns that you would like to discuss with a doctor at this time?	( )	( )
53	Do you know of or do you believe there is any health reason why you should not participate in Catawba athletics at this time?	( )	( )
	FEMALES ONLY		
54	Have you ever had a menstrual period?	( )	( )
55	How old were you when you had your first menstrual period?		
56	How many periods have you had in the past 12 months?		

Explain "Yes" answers here: _____

The undersigned, herewith,

- Give authorization to the team physician, athletic trainer, physical therapist, and other sports medicine consultants to evaluate and treat any injuries that occur as a result of my athletic participation at Catawba. This includes and is not limited to immediate first aid treatment, physical exam, medical imaging tests, follow-up care and rehabilitation in the Catawba Athletic Training Room;
- Understands that I must refrain from practice or play while ill or injured, whether or not receiving medical treatment until I am discharged from treatment or am given permission by the clinical practitioner to restart participation despite continuing treatment;
- Understands that having passed the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me at time of said examination; and
- States that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature: _____ **Date:** _____

Parent or Witness' Signature: _____ **Date:** _____

PHOTOCOPIES WILL NOT BE ACCEPTED!

CATAWBA COLLEGE SPORTS MEDICINE

Preparticipation Physical
Photocopies NOT Accepted

NAME _____ **DATE OF BIRTH** _____ **SPORT** _____

HEIGHT _____ **WEIGHT** _____ **BP** ____/____ ; ____/____ **PULSE** _____

VISION R 20/_____ L 20/_____ **CORRECTED?** Y / N **PUPILS** EQUAL / UNEQUAL

	NORMAL	ABNORMAL FINDING / HISTORY
Appearance	( )	
Eyes/ears/nose/throat	( )	
Hearing	( )	
Lymph Nodes	( )	
Cardiopulmonary		
Auscultations (murmurs)		Supine _____ Standing _____ Pulses: Brachial _____ Femoral _____
Lungs	( )	
Marfan's	( )	Arm span>height _____ Kyphoscoliosis _____ Concave chest _____ + Thumb/wrist _____
		High arch/palate/feet _____ Inguinal Hernia _____ Nearsighted _____ Heart murmur _____
Tanner Stage		1 2 3 4 5
Skin	( )	
Abdomen	( )	
Genitourinary	( )	

Musculoskeletal	NORMAL	ABNORMAL FINDING / HISTORY
Head	( )	
Neck	( )	
Back	( )	
Shoulder/arm	( )	
Elbow/forearm	( )	
Wrist/hand/fingers	( )	
Hip/thigh	( )	
Knee	( )	
Leg/ankle	( )	
Foot/toes	( )	

Blood	Sickle Cell Test	Disease: Positive / Negative	Trait: Positive / Negative
Urinalysis	Sugar _____	Albumin _____	Micro, if indicated _____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the institution and the student's medical history as furnished to me, this student is:

( ) CLEARED WITHOUT RESTRICTION

( ) CLEARED, WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR: _____

( ) NOT CLEARED

( ) FOR ALL SPORTS

( ) FOR CERTAIN SPORTS Please explain / give reason _____

_____ _____

Name of Physician (print) Date

_____ ( )

Physician Address City State Zip Phone

_____, MD or DO

Signature of Physician

_____ _____

Athlete's Signature Date

_____ _____

Parent/Guardian Signature (If athlete is under 18 years of age) Date