Old Dominion University Preparticipation Physical Evaluation
History Form

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart)

Date of Exam_____

Name _____ Date of Birth _____ Age_____ Sex_____

UIN _____ Sport _____ Year of Eligibility _____

Medicines and Allergies: Please list all of the prescriptions and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

_____

_____

Do you have any allergies? Yes No If yes, please identify specific allergy below

☐ Medicine ☐ Pollen ☐ Food ☐ Stinging Insects ☐ Other_____

GENERAL QUESTIONS	Yes	No
1. Has a doctor denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: O Asthma O Anemia O Diabetes O Infections Other:_____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, tightness, pressure or pain in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: O High blood pressure O A heart murmur O High cholesterol O A heart infection O Kawasaki disease Other:_____		
9. Has a doctor ever ordered a test for your heart? (For example ECG/EKG, echocardiogram)		
10. Do you feel lightheaded or more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more short of breath quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you currently have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medication?		
28. Is there anyone in your family that has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have any groin pain or painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last year?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a MRSA or herpes skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or fallen?		
39. Have you ever been unable to move your arms or legs after being hit or fallen?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contacts lenses? O glasses O contact lenses		
46. Do you wear any protective eyewear, such as goggles or face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns you would like to discuss with as doctor?		
FEMALES ONLY	Yes	No
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period? _____		
54. How many periods have you had in the last 12 months? _____		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of physician_____ Date_____

Signature of Athletic Trainer *(ODU use only)* _____ Date_____

ATHLETIC TRAINING DEPARTMENT ASSUMPTION OF RISK STATEMENT

I, _____, as a student-athlete at Old Dominion University accept the responsibility of reporting any injuries and illnesses to the institutional medical staff, including signs and symptoms of head injury. I am also aware of and accept the risk of serious injury that may render me disabled or paralyzed as a result of the intercollegiate sport(s) in which I will be participating as a student-athlete. I will do my part to reduce the injury risk by keeping myself in the best possible condition and will follow the advice of the team physician(s), athletic trainers, and health clinic personnel concerning the prevention, treatment, rehabilitation and maintenance of any athletic injury. All of the questions in this form have been answered completely and truthfully to the best of my knowledge.

Signature of Athlete _____ *Date* _____

Old Dominion University Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name_____ UIN _____ Date of Birth_____

Examination			
Height	Weight		☐Male ☐Female
BP	Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐N

Medical	Normal	Abnormal Findings
Appearance		
Eyes/ears/nose/throat		
Lymph Nodes **		
Heart		
Pulses **		
Lungs		
Abdomen		
Genitourinary (males only) **		
Skin		
Neurologic		
Musculoskeletal		
Neck		
Back		
Shoulder /Arm/ Hand		
Hip/ thigh		
Knee		
Leg /ankle/ Foot		
Balance Testing Test will be performed on firm surface standing on each leg alternately for 7 seconds with eyes closed. Types of errors: • Hands lifted off iliac crest • Opening eyes • Step, stumble, fall • Moving hips into >30 degrees abduction • Lifting forefoot or heel • Remaining out of test position for > 5 seconds	R	L
Sickle Cell ☐ Positive ☐ Negative (Please include copy of lab results)		

***** If Medically Indicated***

☐ Cleared for all sports without restrictions

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

_____

☐ Not Cleared

Reason _____

Recommendations_____

_____

_____

Name of Physician (print/type) _____ Date _____

Office Address_____ Phone _____

Signature of physician_____

Signature of Athletic Trainer *(ODU use only)* _____ Date_____