SDSU Preparticipation Physical Evaluation

Date Form Completed: ____/____/____

Name:	Sex:	Age:	Date of Birth:
Varsity Sport:	Cell Phone:	Email:	
Local Address:			
Red ID #:			

Explain "Yes" answers, more space in box at end.
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? Why_____	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)? List:	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? List:	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects? If so, what?_____	☐	☐
5. Have you ever passed out or nearly passed out **DURING** exercise?	☐	☐
6. Have you ever passed our 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 a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection	☐	☐
10. Has a doctor ever ordered a test for your heart (for example, ECG, echocardiogram)?	☐	☐
11. Has anyone in your family 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 in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery? If so, on what?	☐	☐
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or game?	☐	☐
18. Have you had any broken or fractured bones or dislocated joints?	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐
If you have answered YES to any of the above questions please complete the Musculoskeletal History Section, page 3/3.		
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or an assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or have you ever been given an inhaler?	☐	☐

	YES	NO
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Do you currently use an inhaler or take asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have an rashes, pressure sores or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion? If so, when was your last one?_____ How many have you had?_____ Any current problems?_____	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommend you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
47. Do you take any medications for ADHD and/or anabolic steroids for any reason?	☐	☐
FEMALES ONLY:		
48. Have you ever had a menstrual period?	☐	☐
49. How old were you when you had your first menstrual period?		
50. How many periods have you had in the last 12 months?		

Please number and explain "Yes" Answers Here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Print Name of athlete: _____ Date: _____

Signature of athlete: _____ Signature of Parent/Guardian: _____

Please check a response for each of the following: I...

	Always	Usually	Often	Sometimes	Rarely	Never	Score
1. Am terrified about being overweight	O	O	O	O	O	O	___
2. Avoid eating when I am hungry	O	O	O	O	O	O	___
3. Find myself preoccupied with food	O	O	O	O	O	O	___
4. Have gone on eating binges where I feel that I may not be able to stop	O	O	O	O	O	O	___
5. Cut my food into small pieces	O	O	O	O	O	O	___
6. Aware of the calorie content of foods that I eat	O	O	O	O	O	O	___
7. Particularly avoid foods with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	O	O	O	O	O	O	___
8. Feel that others would prefer if I ate more	O	O	O	O	O	O	___
9. Vomit after I have eaten	O	O	O	O	O	O	___
10. Feel extremely guilty after eating	O	O	O	O	O	O	___
11. Am preoccupied with a desire to be thinner	O	O	O	O	O	O	___
12. Think about burning up calories when I exercise	O	O	O	O	O	O	___
13. Other people think that I am too thin	O	O	O	O	O	O	___
14. Am preoccupied with the thought of having fat on my body	O	O	O	O	O	O	___
15. Take longer than others to eat my meals	O	O	O	O	O	O	___
16. Avoid foods with sugar in them	O	O	O	O	O	O	___
17. Eat diet foods	O	O	O	O	O	O	___
18. Feel that food controls my life	O	O	O	O	O	O	___
19. Display self-control around food	O	O	O	O	O	O	___
20. Feel that others pressure me to eat	O	O	O	O	O	O	___
21. Give too much time and thought to food	O	O	O	O	O	O	___
22. Feel uncomfortable after eating sweets	O	O	O	O	O	O	___
23. Engage in dieting behavior	O	O	O	O	O	O	___
24. Like my stomach to be empty	O	O	O	O	O	O	___
25. Enjoy trying new rich foods	O	O	O	O	O	O	___
26. Have the impulse to vomit after meals	O	O	O	O	O	O	___

1. Have you gone on eating binges where you feel that you may not be able to stop? (Eating much more than most people would eat under the same circumstances?)
   No _____ Yes_____ How many times in the last 6 months? _____
1. Have you ever made yourself sick (vomited) to control your weight or shape?
   No_____ Yes_____ How many times in the last 6 months? _____
2. Have you ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?
   No_____ Yes_____ How many times in the last 6 months? _____
3. Have you ever been treated for an eating disorder?
   No_____ Yes_____ How many times in the last 6 months? _____
4. Have you recently thought of or attempted suicide?
   No_____ Yes_____ When? _____

Have you ever been diagnosed as having an eating disorder (anorexia, bulimia, or both)?
No _____ Yes _____

Please list your:
highest weight _____, lowest weight _____, goal weight _____

Print Name of athlete: _____ Date: ____ / ____ / ____

Signature of athlete: _____

Musculoskeletal History Section:

Please list fractures, sprains, strains, dislocations, cartilage injuries, etc.
If you need more room use lines at end of the section.

		Type of Injury	Date	Treatment	Fully Resolved
Ankle	R				☐ yes ☐no
	L				☐ yes ☐no
Foot	R				☐ yes ☐no
	L				☐ yes ☐no
Knee	R				☐ yes ☐no
	L				☐ yes ☐no
Hip/Leg	R				☐ yes ☐no
	L				☐ yes ☐no
Hand	R				☐ yes ☐no
	L				☐ yes ☐no
Wrist	R				☐ yes ☐no
	L				☐ yes ☐no
Elbow	R				☐ yes ☐no
	L				☐ yes ☐no
Shoulder	R				☐ yes ☐no
	L				☐ yes ☐no
Chest/Ribs					☐ yes ☐no
Neck (burners, stingers, etc)					☐ yes ☐no
Back					☐ yes ☐no
Head/Face					☐ yes ☐no

Any other significant injury to your body? (please explain)_____

_____

General Questions:

Have you ever been hospitalized overnight? (please explain) _____

_____

Have you ever had any surgeries? (please explain) _____

_____

Do you have ANY medical problems you have not yet listed that require regular treatment or medical attention?

_____

Have you seen a doctor in the last year? _____

Are you currently experiencing any symptoms or in any way feel not well? _____

I hereby certify that I have completed this questionnaire completely and correctly to the best of my ability and knowledge. I certify that there are no illnesses or injuries, current or previous, that I have incurred, other than those I have listed on the preceding pages.

Print Name of athlete: _____ Date: ____/____/____

Signature of athlete: _____

San Diego State University
Preparticipation Medical Examination-Sport Clubs/ROTC/Misc.

Name: _____ **SDSU Red ID#:**_____ - _____ - _____

Sport: _____ **Date:** _____/_____/_____

I. I have not had any illness or injury; or developed any new symptoms since I completed the Health History Form on _____.

Signature _____

II. Health History Form reviewed (Staff initials _____)

If Ht. > 6'0" male or 5'10" female measure:
Symph to floor = _____ arm span _____
UB/LB ratio _____ **is is not** < 0.89
Arm span/height _____ **is is not** > 1.05

EXAM: Height: _____ Weight: _____ (%) Pulse: _____ BP: _____/_____

Vision: R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal ___ Unequal_____

MEDICAL	**Normal**	**Abnormal Findings**	
Appearance			
Eye/Ears/Nose /Throat			
Neuro			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL		**Medical exam performed by:**	
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			
Other		☐ No physical stigmata of Marfan's	

Orthopedic exam performed by:

CLEARANCE:

☐ Cleared - Based on my examination of this patient, I determine he/she can fully participate in intercollegiate athletics at SDSU

☐ Cleared after completing rehabilitation for: _____

_____

☐ Not cleared for: _____ Reason: _____

☐ Clearance decision deferred pending further work-up or obtaining records

COMMENTS and RECOMMENDATIONS:

_____

Signature of physician **Name of physician** **Date**

Office Phone: _____ **Fax:** _____

San Diego State University
Clearance Form
Sport Clubs/ ROTC/Misc.

Name: _____
ID#: _____
DOB: _____

□Cleared without restriction
□Cleared, with recommendations for further evaluation or treatment for: _____
_____

□ Clearance DEFFERRED, pending evaluation as follows: _____
_____

□Not cleared for □All Sports □Certain Sports: _____ Reason: _____

Other Recommendations: _____

Name of Physician (print/type) _____ Date_____

Address_____
Phone: _____Fax:_____

Signature of Physician _____

Reviewed and Concur: _____
SDSU Athletic Medicine Staff

San Diego State University
Clearance Form
Sport Clubs/ ROTC/Misc.

Name: _____
ID#: _____
DOB: _____

□Cleared without restriction
□Cleared, with recommendations for further evaluation or treatment for: _____
_____

□ Clearance DEFFERRED, pending evaluation as follows: _____
_____

□Not cleared for □All Sports □Certain Sports: _____ Reason: _____

Other Recommendations: _____

Name of Physician (print/type) _____ Date_____

Address_____
Phone: _____Fax:_____

Signature of Physician _____

Reviewed and Concur: _____
SDSU Athletic Medicine Staff