New Student-Athlete Preparticipation Physical Evaluation (Blue)

Name_____ Sport_____ VT ID#_____

Date of Exam _____ Date of Birth_____ Year in School _____

Mark "yes" or "no" for all answers, and explain "yes" answers below

	Yes	No
1. Have you had any illness or injury since your last check up or sport physical?	☐	☐
2. Do you have an ongoing or chronic illness?	☐	☐
3. Have you ever been hospitalized overnight?	☐	☐
4. Have you ever had surgery?	☐	☐
5. Are you currently taking any prescription, non-prescription, over-the-counter medications, pills, or using an inhaler? Please list:	☐	☐
6. **Have you ever been tested for or diagnosed with ADD/ADHD, anxiety, depression, or eating disorders?**	☐	☐
7. Have you ever taken any supplements/vitamins to help you gain or lose weight?	☐	☐
8. Have you ever taken any supplements/vitamins to help athletic performance?	☐	☐
9. Do you have any allergies (i.e. pollen or seasonal, medicine, bees, foods)?	☐	☐
10. Have you ever had a rash or hives develop during or after exercise?	☐	☐
11. Have you ever passed out during or after exercise?	☐	☐
12. Have you ever been dizzy during or after exercise?	☐	☐
13. Have you ever experienced severe cramping during exercise?	☐	☐
14. **Have you or a family member been diagnosed with sickle cell disease or trait?**	☐	☐
15. Have you ever been dizzy, passed out or become ill from exercising in the heat?	☐	☐
16. Have you ever had chest pain during or after exercise?	☐	☐
17. Do you get tired more quickly than your friends during exercise?	☐	☐
18. Have you ever had a racing of your heart or skipped heart beats?	☐	☐
19. Have you ever been diagnosed with any of the following: ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection		
20. Has a doctor ever ordered a test for your heart (i.e. an EKG or echo)?	☐	☐
21. Has anyone in your family died or been disabled from a heart problem or sudden death before the age of 50?	☐	☐
22. Have you had a severe viral infection (i.e. myocarditis or mono) within the last month?	☐	☐
23. Has a physician ever denied or restricted your participation in sports for any heart-related problems?	☐	☐
24. Do you have specific knowledge of certain cardiac conditions in family members (i.e. hypertrophic/dilated cardiomyopathy, long QT syndrome, any ion channelopathies, Marfan syndrome, arrhythmias)?	☐	☐
25. Have you ever been knocked unconscious or suffered a concussion?	☐	☐
26. Have you ever had a seizure?	☐	☐
27. Do you have frequent or severe headaches?	☐	☐
28. Have you ever had numbness, tingling in your arms, hands, legs or feet?	☐	☐
29. Have you ever had a stinger, burner or pinched nerve?	☐	☐
30. Do you cough, wheeze, or have trouble breathing during or after exercise?	☐	☐
31. Do you have asthma?	☐	☐
32. Do you use any special protective or corrective equipment that aren't usually used for your sport (i.e. braces, orthotics, retainers, hearing aids)?	☐	☐
33. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
34. Have you had any problems with your eyes or vision?	☐	☐
35. Do you wear glasses, contacts or protective eyewear?	☐	☐
36. Have you ever had a sprain, strain or swelling after an injury?	☐	☐
37. Have you ever broken, fractured or dislocated any bones or joints, including stress fractures?	☐	☐
38. Have you had any problems with pain or swelling in muscles, tendons, bones or joints? If YES, please check and explain in space below: ☐ Head ☐ Elbow/Forearm ☐ Knee ☐ Neck/Back ☐ Wrist/Hand/Fingers ☐ Shins ☐ Chest/Shoulder ☐ Hip/Thigh ☐ Ankle/Foot	☐	☐
39. Do you want to weigh more or less than you do now?	☐	☐
40. Do you lose weight regularly to meet sport weight requirements?	☐	☐

41. How many years have you played contact sports? _____

42. Over the past 2 weeks how often have you been bothered by any of the following problems?

a. Little interest or pleasure in doing things:

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

b. Feeling down, depressed, or hopeless:

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

Females Only:

1. What age was your first menstrual period?
2. When was your most recent menstrual period?
3. How much time do you have between the start of one period to the start of another?
4. How many periods have you had in the last year?
5. What was your longest time between periods?
6. Are you currently taking birth control pills? Yes or No
   Name of prescription:
7. Have you ever had a pelvic/Pap smear? Yes or No
   Date:

Explain any "yes" answers here:

PREPARTICIPATION PHYSICAL EXAMINATION

Name _____

Height _____	Vision: R 20/	Peak Flow _____	
Weight _____	L 20/		
Pulse _____	Corrected: Yes	No	
Right BP _____	Contacts	Glasses	
Left BP _____	Pupils: Equal	Unequal	

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Marfan Screen			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			

	Normal	Abnormal Findings	Initials
Musculoskeletal			
Neck			
Back			
Shoulder			
Arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Clearance

□ Cleared

□ Not Cleared For Reason:

Recommendations:

Physician Name:

Date _____

Address: 150 Jamerson Athletic Center

Phone: 540-231-6410

Signature of Physician: _____ DO or MD _____

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

Signature of Athlete