

PENN COLLEGE SPORTS MEDICINE DEPARTMENT
Pre-participation Health Questionnaire & Physical Examination
(Please print)

Name _____ Sport(s) _____
(Last) (First) (MI)
Birth Date ____/____/____ Age _____ SSN: _____ - _____ - _____ Student ID: _____
Local Phone (____) _____ Cell Phone (____) _____
Local Address _____ City/State/Zip _____
Home Phone (____) _____ Parent Work/Other Phone (____) _____
Home Address _____ Home City/State/Zip _____

Past Medical History

Circle Y or N – please explain

- | | |
|--|-----------|
| 1. Are you presently taking medication? (please list) | Y N _____ |
| 2. Are you presently taking vitamins or dietary supplements? (please list) | Y N _____ |
| 3. Do you have any known allergies (medicine, bee stings, latex, etc)? (please list) | Y N _____ |
| 4. Do you wear glasses, contact lenses, safety glasses, or hearing aid? | Y N _____ |
| 5. Do you have a history of dental injuries, braces, bridges, or removable appliances? | Y N _____ |
| 6. Have you been diagnosed with asthma, seizure disorders, diabetes, or other chronic illness? | Y N _____ |
| 7. Have you been recently diagnosed with infectious mononucleosis, hepatitis B or C, HIV/AIDS, or any other severe infectious disease/viral infection? | Y N _____ |
| 8. Have you had any surgical procedures? | Y N _____ |
| 9. Have you had any significant musculoskeletal injuries requiring doctor, x-rays, or MRI? | Y N _____ |
| 10. Have you had any injuries connected to sports requiring missed practices/games? | Y N _____ |
| 11. Have you had any hospitalization/surgery not explained above? | Y N _____ |
| 12. Do you have any known deformities (such as curvature of back)? | Y N _____ |
| 13. Are you aware of any serious family illness (diabetes, bleeding disorders, etc)? | Y N _____ |
| 14. Have you ever felt dizzy, lightheaded, or passed out during or after exercise/activity? | Y N _____ |
| 15. Do you only have one of two paired functioning organs (eye, kidney, testicle/ovary)? | Y N _____ |
| 16. Have you ever had a heat related illness (heat exhaustion, heat stroke)? | Y N _____ |
| 17. Have you suffered a head injury/concussion and/or loss of consciousness? | Y N _____ |
| 18. Has a family member under the age of 50 died suddenly from non-traumatic cause? | Y N _____ |
| 19. Are you aware of a family history of Marfan Syndrome? | Y N _____ |
| 20. Have you had any known exposure to Tuberculosis? | Y N _____ |
| 21. Do you have a history of chest pain, cardiac disease/symptoms (Tests: EKG, stress tests)? | Y N _____ |
| 22. Do you have any current health problems that you would like to discuss with the doctor today? | Y N _____ |
| 23. Have you ever been told by a physician to restrict your sports activity or not to participate in a sport? | Y N _____ |
| 24. Do you believe there is any reason why you should not participate in intercollegiate athletics at the Pennsylvania College of Technology? | Y N _____ |
| 25. Do you have any current health problems which could impair your sports performance? | Y N _____ |

I hereby affirm all my answers are truthful and correct. Signed: _____ Date: _____

This section **MUST** be filled out by a Physician

VITALS:

Height _____ Weight _____
Blood Pressure _____ / _____ Heart Rate _____
Vision **right-** 20 / _____ **left-** 20 / _____ Corrected- YES NO

PHYSICAL EXAM:

	NORMAL	ABNORMAL FINDINGS
Skin	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	
Nose	<input type="checkbox"/>	
Mouth/Tongue	<input type="checkbox"/>	
Lymph Nodes	<input type="checkbox"/>	
Heart/Cardiovascular	<input type="checkbox"/>	
Lungs/Pulmonary	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Genitalia (Hernia/Testicles)	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
Orthopedic (Spine)	<input type="checkbox"/>	
Orthopedic (Upper Extremity)	<input type="checkbox"/>	
Orthopedic (Lower Extremity)	<input type="checkbox"/>	

RECOMMENDATIONS / COMMENTS: _____

STATUS:

- Pass without restrictions
- Pass with restrictions _____
- Further Evaluation Needed- Appt. with _____ Appt Date _____

_____ Examiner's Signature	_____ Date
_____ Examiner Name and Address (print or stamp)	