SC Sports Medicine

Pre-participation Physical Exam

Student-Athlete's Name: _____ Date of Birth: _____
Last First Middle

Sport(s): _____ Academic Year: _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Home Address: _____

School Address: _____
Street/PO Box City State Zip

Parent/Guardian: _____

Address: _____
Street/PO Box City State Zip

Permanent Phone #: _____

Name of Family Physician: _____

Address: _____
Street/PO Box City State Zip

Telephone of Family Physician: _____ Date of last examination: _____

Have you ever had or have now any of the following?

Allergy	Yes _____	No _____	Measles	Yes _____	No _____
Asthma	Yes _____	No _____	Rheumatic Fever	Yes _____	No _____
Concussion	Yes _____	No _____	Seizure/Epilepsy	Yes _____	No _____
Diabetes	Yes _____	No _____	Sickle Cell	Yes _____	No _____
Heart Murmur	Yes _____	No _____	Tuberculosis	Yes _____	No _____
Mental Problem	Yes _____	No _____	Eating Disorder	Yes _____	No _____
Heat Problems	Yes _____	No _____	Abnormal Heart Beat	Yes _____	No _____
Hepatitis	Yes _____	No _____	Chest Pain	Yes _____	No _____
Hernia	Yes _____	No _____	Shortness of Breath	Yes _____	No _____
High Blood Pressure	Yes _____	No _____	Mononucleosis	Yes _____	No _____
Birth Deformities	Yes _____	No _____	Pneumonia	Yes _____	No _____
High/Low Blood Sugar	Yes _____	No _____			

Please explain fully if "YES" to any question above:

Have you ever had an illness/injury involving the following?

Head	Yes _____	No _____	Hand	Yes _____	No _____
Shoulder	Yes _____	No _____	Calf	Yes _____	No _____
Wrist	Yes _____	No _____	Heart	Yes _____	No _____
Hip	Yes _____	No _____	Back	Yes _____	No _____
Knee	Yes _____	No _____	Elbow	Yes _____	No _____
Foot	Yes _____	No _____	Chest/Breast	Yes _____	No _____
Neck	Yes _____	No _____	Abdomen/Pelvis	Yes _____	No _____
Arm	Yes _____	No _____	Ankle	Yes _____	No _____

Please explain fully if "**YES**" to any question above including any surgeries:

Has a doctor ever denied or restricted your participation in sports for any reason (illness, concussion, blood pressure, etc.)?

List all current medications (including birth control pills, vitamins and supplements):

Date of last Tetanus shot: _____

List all medications to which you are allergic (include reaction):

Have you ever been knocked out, become unconscious, or lost your memory? (Explain--how many times, date of your last concussion, etc.)

Have you had any surgeries in the past year? Are you cleared to participate in sports at Southwestern College?

Were you born without or are you missing a kidney, an eye, testicles, or any other organ? (Explain)

Have you ever been unable to move your arms or legs after being hit or falling?

Have you ever had any injury or illness than those already covered?

Has anyone in your family, **under the age of 50** died suddenly of the following?

Marfan's Syndrome	Yes _____	No _____	Heart Trouble	Yes _____	No _____
Diabetes	Yes _____	No _____	High Blood Pressure	Yes _____	No _____
Asthma or Allergies	Yes _____	No _____	A Stroke	Yes _____	No _____
HCM or Long QT	Yes _____	No _____	Bleeding or Circulatory Problems	Yes _____	No _____

Please explain fully if "YES" to any question above:

Sickle Cell Anemia

1) Have you ever been tested for Sickle Cell Anemia that you are aware of?
   Yes _____ No _____
   a. Date: _____
   b. Result?

2) Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of?
   Yes _____ No _____
   a. Please describe :

3) Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia?
   Yes _____ No _____
   a. Please describe:

Females only

1) When was your first menstrual period? _____
2) When was your most recent menstrual period? _____
3) How many periods have you had in the last year? _____
4) How long are your periods? _____
5) Have you ever been treated for anemia (low hemoglobin or iron)? _____

Heat Acclimatization / Performance Enhancing

1) Have you ever had any form of heat stress problems before? If yes, please check which one.

   A) Heat exhaustion _____
   B) Heat stroke _____
   C) Dizziness _____
   D) Fainting _____

2) If you answered yes to the above question, how many times did that particular problem occur and when did it happen?

3) Were you on any form of conditioning program during the summer? If the answer is yes, briefly explain your program.

4) Are you presently on a diet? If yes, what kind of diet? Who designed it?

5) Have you been restricting your water intake for any reason? If yes, explain why.

6) Are you currently taking any performance enhancing supplements? If yes please indicate all the supplements that you are taking and how often.

7) Are you anticipating taking any additional supplements during the season? If yes, what are you planning on taking?

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

Student-Athlete's Signature: _____ Date: _____

Physical Portion

Name: _____ Date: _____ Sport(s): _____
Height: _____ (in) Weight: _____ (lbs.)
Pulse: _____ Blood Pressure: _____/_____
Vision: R 20 /_____ L 20 /_____ Corrected: Yes _____ No _____ Pupils: Equal _____ Unequal _____

Orthopedic Screening

Neck/Spine	
Shoulders/Arm	
Hands/Wrists	
Back	
Hips/Thighs	
Knees	
Ankles/Feet	

General Medical Screening

Eyes	
Ears	
Mouth/Throat	
Chest/Lungs	
Heart	
Abdomen	
Genitalia (Males only)	

Participation Recommendations:

☐ Pass

☐ Pass with conditions: _____
_____
_____

☐ Fail: _____
_____
_____

Recommendations: _____
_____
_____

The following information must be filled in and signed by either:

1) **Physician (MD or DO)**
2) **Physician Assistant (PA-C)**
3) **Registered Nurse Practitioner (ARNP)**

****Examination forms signed by any other health care practitioner will not be accepted.****

Physician's Name: _____ Date: _____

Address: _____

Street/PO Box City State Zip

Physician's Phone: _____

Physician's Signature: _____

This must be completed before a student-athlete participates in any practice, (both in-season and out-of-season) or game/match.