ROBERTS WESLEYAN COLLEGE

SPORTS Pre-participation Physical Evaluation

(to be completed by the student athlete & Medical Provider)

(To be complete by student athlete)

Name: ____ Gender: __________ Birthdate: ______/______/_______

Cell Phone: ___________________ Home Phone: ___________________ Email: ______________________________________

Circle: FR SO JR SR Sports: _________________________ ________________________ _________________________

MEDICAL ISSUES:

1. Have you had a medical illness (particularly a severe viral or flu-like illness) or injury since your last checkup or sports physical? YES NO
2. Have you had infectious mononucleosis (“mono”)? YES NO
3. Do you have any ongoing/chronic medical illnesses (diabetes, heart condition, etc.)? YES NO
4. Do you have asthma? YES NO
5. Do you have trouble breathing, cough, or wheeze during or after exercise? YES NO
6. Have you been hospitalized overnight? *If so, please describe on back of page.* YES NO
7. Have you seen a doctor because of an injury? YES NO
8. Have you had surgery? *If so, please describe on back of page.* YES NO

MEDICATIONS/SUPPLEMENTS: (Last 12 Months Only)

9. Are you regularly taking any medications (prescription or non-prescription) or using an inhaler? PLEASE INCLUDE BIRTH CONTROL, ADDERALL/RITALIN *If so, please describe on back of page.* YES NO
10. Have you been diagnosed with attention deficit disorder (ADD)? NOTE: THE NCAA REQUIRES DOCUMENTATION OF FORMAL ADD TESTING YES NO
11. Are you presently taking vitamins, supplements to gain or lose weight, or supplements to aid performance? ALL SUPPLEMENT USE MUST BE REPORTED! YES NO

ALLERGIES: (Last 12 Months Only)

12. Do you have any allergies to medications, pollens, foods, or stinging insects? YES NO
13. Have you developed a rash or hives during or after exercise? YES NO

HEART ISSUES:

14. Have you had chest pain during or after exercise? *If so, please describe on back of page.* YES NO
15. Have you been told that you have a heart murmur? YES NO
16. Have you “passed out” during or after exercise? YES NO
17. Have you felt dizzy during or after practice or competition? YES NO
18. Do you tire more quickly with exertion than your teammates? YES NO
19. Have you been diagnosed with high blood pressure or high cholesterol? YES NO
20. Have you had an electrocardiogram (EKG), echocardiogram (sound wave test of the heart), or been evaluated by a heart specialist? YES NO
21. Have you had severe or repeated racing of your heart or skipped heartbeats? YES NO
22. Has anyone in your family died of heart problems or of sudden death before age 50? YES NO
23. Has a physician denied or restricted your athletic participation for any reason? YES NO

NEUROLOGIC ISSUES:

24. Have you had a head injury or concussion? *If so, please describe on back of page.* YES NO
25. Have you been “knocked out,” lost consciousness, or lost memory? YES NO
26. Have you had a seizure? YES NO
27. Do you suffer from frequent or severe headaches, particularly with exercise? YES NO
28. Have you had a “stinger,” “burner,” or pinched nerve? YES NO
29. Have you experienced numbness or tingling in your arms, hands, legs, or feet after being hit or falling? YES NO

ORTHOPAEDIC ISSUES:

30. Have you had broken bones, dislocations, sprains or tendonitis that caused you to miss a practice or game? YES NO
31. Have you had a stress fracture? YES NO
32. Do you use any special equipment (braces, neck rolls, eye guards, orthotics, etc.)? YES NO

NUTRITION: (Last 12 Months Only)

33. Do you have concerns about your EATING HABITS or have you been diagnosed with an EATING DISORDER or IRON DEFICIENCY/ANEMIA? YES NO
34. Do you want to weigh more or less than you do? YES NO
35. Do you lose weight regularly to meet the weight requirements/demands of your sport? YES NO
36. Do you often skip meals or strictly limit/control what you eat? YES NO

MISCELLANEOUS CONCERNS:

37. Have you or a family member been diagnosed with SICKLE CELL DISEASE/TRAIT? YES NO
38. When exercising in the heat, do you have severe muscle cramps or become ill? YES NO
39. Have you been diagnosed with depression, anxiety, or panic attacks? YES NO
40. Have you had any skin problems (acne, warts, herpes, etc)? YES NO
41. Have you had any trouble with your eyes or vision? YES NO
42. Do you wear contact lenses/glasses? YES NO

FOR WOMEN ONLY:

1. At what age was your first menstrual period?___________________________
2. When was your last menstrual period? _________________________________
3. What was the longest time between periods last year?____________________
4. How many menstrual periods did you have in the last 12 months? _________
5. Have you previously or are now on birth control pills? __________

Explain “Yes” answers below.

____

____

____

Please list any additional comments that you wish to make about your medical history.

____

____

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

____ _______ / ________ / ________

Signature of athlete: Date:

____ _______ / ________ / ________

Signature of parent/guardian if student is under 18: Date:

Student information:	
Name:	**Date of Birth:**
Intercollegiate Sports(s)	**Gender:**
Date of Physical:	**Year in School:** FR SO JR SR

Examination *(Physical must be dated within a year) (Athletic physical must be dated within six months of sports participation)*

Height:	**Weight:**	**BP:**	**Pulse:**	**BMI:**

Vision Corrected: ❒ Yes ❒ No L 20/ R 20/	**Pupils:** Equal / Unequal

	Normal	Abnormal or significant findings
General		
Appearance		
HEENT		
Lung		
Heart Murmurs, (auscultation standing, supine)		
Endocrine/Lymph Nodes		
Abdominal		
Genialia (males only)		
Pulses Radial pulses & Simultaneous femoral		
Neurologic		
Skin		
Musculoskeletal		
Neck/Shoulder/Back		
Arm/Elbow/Wrist/Hand/Fingers		
Leg/Hip/Thigh/Knee		
Ankle/Foot/Toes		

Does the student have drug allergies? If yes, please list by name and type of reaction: ____

____

Recommendations/Comments regarding the chronic condition or serious illness continuing care of the student:

____

____

Recommendations/Comments regarding the emotional, continuing care of the student:

____

____

❒ Cleared to participate in a full program college study

❒ Cleared for all sports without restrictions

❒ Cleared for all sport without restriction with recommendations for further evaluation or treatment for ______________________________

❒ Not cleared for sports ❒ Not cleared for college study

❒ Pending further evaluation

Reason and recommendations ____

____

Medical provider signature/stamp or a copy of the medical provider's document must be attached. **STAMP**

____

MD, NP, or PA's Signature

____

MD, NP, or PA's Printed Name

____

Address, City, State