PRE-PARTICIPATION PHYSICAL EXAMINATION.

SPORTS MEDICINE

Please complete this document, and sign (parent/guardian signature required if younger than 18). Bring the completed document to your physical appointment. Pages 1-3 are to be filled out by the patient. Page 4 is to be filled out by your provider during your evaluation.

For this document to be considered valid all 4 pages must be entirely filled out, participation eligibility determined by your provider, signed, and dated by your provider. GV reserves the right to deem this document invalid if any components are absent.

Name:_____ Date of Birth:_____

Examination Date:_____

Primary Physician:_____ Emergency Contact Name:_____

Primary Physician Clinic:_____ Emergency Contact Relationship:_____

Primary Clinic Phone # & Location:_____ Emergency Contact Phone #:_____

_____

Please select which team(s) you will be joining at GVU: If you are a nursing student, please indicate with a *"YES"* here:_____

☐	Baseball	☐	M Basketball	☐	M T&F/XC	☐	M Soccer	☐	M Volleyball	☐	M Wrestling	☐	Football
☐	Softball	☐	W Basketball	☐	W T&F/XC	☐	W Soccer	☐	W Volleyball	☐	W Wrestling		
☐	M/W Bowling	☐	M/W Golf	☐	M/W Tennis	☐	Dance	☐	Cheer	☐	Shooting / Archery		

Medical History:

List past and current medical conditions. Please indicate whether you have stopped or are currently taking each medication.

_____

Have you ever had a surgery? If "yes", list all past surgical procedures.

_____

List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional) that you are taking.

_____

Do you have any allergies? If yes, please list all your allergies (to medicines, pollen, food, stinging insects, etc.)

_____

PHQ-9: Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle Response)

	Not at all	Several Days	More than half the days	Nearly Every day
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3
Trouble falling or staying asleep or sleeping too much.	0	1	2	3
Feeling tired or having little energy.	0	1	2	3
Poor appetite or overeating.	0	1	2	3
Feeling bad about yourself. Or that your failure or have let yourself or family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV.	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite. Being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thought that you would be better off dead or hurting yourself in some way.	0	1	2	3

TOTAL SCORE (Add all numbers circled): _____

If you circled any problems in the exercise above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very Difficult Extremely Difficult

General Questions:

Y	N	
☐	☐	Do you have any concerns that you would like to discuss with your provider?
☐	☐	Has a provider ever denied or restricted your participation in sport for any reason?
☐	☐	Do you have any ongoing medical issues or recent illnesses?
☐	☐	Have you had any new medical diagnoses or injuries since your last physical evaluation?

Heart Health Questions:

Y	N	
☐	☐	Have you ever passed out or nearly passed out during or after exercise?
☐	☐	Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?
☐	☐	Does your heart ever race, flutter in your chest, or skip beats (have irregular beats) during exercise?
☐	☐	Has a doctor ever told you that you have any heart problems?
☐	☐	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?
☐	☐	Do you get lightheaded or feel shorter of breath more quickly than your friends during exercise?
☐	☐	Do you have high blood pressure or high cholesterol?

Questions about your family:

Y	N	
☐	☐	Have you or any of your immediate family members know to have inherited sickle cell trait, or been tested for SCT?
☐	☐	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (Including drowning or unexplained car crash)
☐	☐	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)?
☐	☐	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?
☐	☐	Does anyone in your family have asthma?

Bone and Joint Questions:

Y	N	
☐	☐	Have you ever had a stress reaction, stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?
☐	☐	Have you had an X-ray, MRI, CT scan or had physical therapy for any reason?
☐	☐	Are you currently experiencing any bone, muscle, ligament, or joint injury or pain that bothers you?
☐	☐	Do you currently, or have you in the past worn orthotics, braces, or other protective equipment for any reason?

Other Medical Questions:

Y	N	
☐	☐	Do you cough, wheeze, or have difficulty breathing during or after exercise? Or have you ever been diagnosed with asthma?
☐	☐	Are you missing a kidney, eye, testicle (males), ovary (females), spleen, or any other organ?
☐	☐	Do you have groin or testicle pain, or painful bulge or hernia in the groin area?
☐	☐	Do you have any recurring skin rashes or rashes that come and go including herpes, MRSA, Impetigo, or Ringworm?
☐	☐	Have you had a concussion, or head injury that caused confusion, a prolonged headache, or memory problems?
☐	☐	Have you ever had a seizure?
☐	☐	Do you get frequent headaches?
☐	☐	Have you ever had numbness, tingling, weakness in your arms or legs, or been able to move your arms or legs after being hit or falling?
☐	☐	have you ever become ill when exercising in heat?
☐	☐	Do you have sickle cell trait or disease? Has anyone in your family had either?
☐	☐	Have you ever had, or do you have any problems with your eyes or vision?
☐	☐	Do you worry about your weight?
☐	☐	Are you trying to or has anyone recommended that you gain or lose weight?
☐	☐	Are you on a special diet or do you avoid certain types of food or food groups?
☐	☐	Have you ever had or been diagnosed with an eating disorder?
☐	☐	Have you ever taken anabolic steroids or used any other performance enhancing supplement?
☐	☐	Have you ever taken any supplements to help you gain or lose weight or to improve your performance?

FEMALES ONLY:

Y	N	
☐	☐	have you ever had a menstrual period?
☐	☐	Is your menstrual cycle regular?
_____		How old were you when you had your first menstrual period?
_____		how many periods have you had in the last 12 months?

Please elaborate here on any of the questions from page 2 you answered "Y":

_____

_____

_____

_____

_____

Orthopedic Screening:

Please use the chart below to provide information on any previous injury or condition you may have sustained throughout your career. Please be as thorough and descriptive as possible. If you have worked with doctors, physical therapists, chiropractors, athletic trainers, etc. under any circumstances, please indicate that appropriately. If you have sustained multiple injuries/surgeries to the same body part, please list the most recent, you can detail past occurrences at the bottom of this form. This is intended to be a complete orthopedic summary of yourself and will provide useful information to the Grand View University Sports Medicine team when making clinical decisions to treat you in the future.

Have you ever sustained an injury or condition to the following body parts?			RIGHT / LEFT/BOTH (Circle one if applicable)	Was your injury surgically corrected? (Circle Y or N if applicable)
NECK			RIGHT / LEFT / BOTH	SURGERY? Y / N
Y ☐	**N** ☐	Diagnosis:		Surgery Date (Month & Year):
SHOULDER			RIGHT / LEFT / BOTH	SURGERY? Y / N
☐	☐	Diagnosis:		Surgery Date (Month & Year):
ELBOW			RIGHT / LEFT / BOTH	SURGERY? Y / N
☐	☐	Diagnosis:		Surgery Date (Month & Year):
WRIST/HAND/FINGERS			RIGHT / LEFT / BOTH	SURGERY? Y / N
☐	☐	Diagnosis:		Surgery Date (Month & Year):
CHEST/ CHEST/ABDOMEN ABDOMEN			RIGHT / LEFT / BOTH	SURGERY? Y / N
☐	☐	Diagnosis:		Surgery Date (Month & Year):
BACK			RIGHT / LEFT / BOTH	SURGERY? Y / N
☐	☐	Diagnosis:		Surgery Date (Month & Year):
HIP			RIGHT / LEFT / BOTH	SURGERY? Y / N
☐	☐	Diagnosis:		Surgery Date (Month & Year):
KNEE			RIGHT / LEFT / BOTH	SURGERY? Y / N
☐	☐	Diagnosis:		Surgery Date (Month & Year):
LOWER LEG			RIGHT / LEFT / BOTH	SURGERY? Y / N
☐	☐	Diagnosis:		Surgery Date (Month & Year):
FOOT/ANKLE			RIGHT / LEFT / BOTH	SURGERY? Y / N
☐	☐	Diagnosis:		Surgery Date (Month & Year):

Please use the area below to provide more detail (if necessary) on any past conditions or injuries you may have sustained throughout your career.

_____

_____

_____

_____

By signing this document, I attest to the best of my knowledge, the answers and information provided are complete and correct.

Student Athlete Signature: _____ Date:_____

Parent or Guardian Signature: _____ Date:_____
(only if Student-Athlete below 18 years old)

Physical Examination – to be filled out by your provider at your appointment.

Height_____ (in / cm) **Weight**_____ (lb / kg) **Blood Pressure** _____/_____ **Pulse** _____ **Temp.**_____ (°F / °C)

Vision: Right 20/_____ Left 20/_____ **Corrected?** (Y / N)

Area	Normal	Abnormal	Area	Normal	Abnormal
Appearance	☐	☐	Neck	☐	☐
Eyes, Ears, Nose, & Throat	☐	☐	Back/Spine	☐	☐
Lymph nodes	☐	☐	Arm/Shoulder	☐	☐
Lungs	☐	☐	Wrist/Hand/Fingers	☐	☐
Abdomen	☐	☐	Hip	☐	☐
Skin	☐	☐	Knee	☐	☐
Neurologic	☐	☐	Leg/Ankle/Foot/Toes	☐	☐
Heart	☐	☐			
Breast	☐	☐			
Hernia	☐	☐			
Thyroid	☐	☐			

Explanation of any abnormal findings or any other comments or concerns of this individual's health:

_____

_____

_____

_____

_____

Participation Eligibility: (One of the following boxes must be checked to consider this examination valid.)

- ☐ Medically cleared for participation in all sports with no restrictions.
- ☐ Medically cleared for participation in all sports with the following restrictions:

  _____
- ☐ Medically cleared for full participation in all sports, except the following sport(s), _____
- ☐ Medical clearance pending further review: (please elaborate) _____
- ☐ Not Eligible for participation in sport.

Name of healthcare provider (print): _____ Date: _____

Address: _____ Phone: _____

Signature of healthcare provider: _____