Minnesota State University, Mankato Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam

																	_
Ν	lame _		Last		First	MI	_Sex		Age			Birthdate		_Sport			_
									Cell #								
School Address															_		
Parent's Name																	
Explain "Yes" answers below.														Yes	— No		
Circle questions you don't know the answers to.					Yes	No		26.	Were you born with	hout or are	you missing	a kidney, an					
1.								07	eye, a testicle, or a								
2.	participation in sports for any reason? Do you have an ongoing medical condition?			П	П		27.	Have you had inference the last month?	ctious mond	onucleosis (r	nono) within	Ш	Ш				
	(like di	abete	es or asth	ma)?							28	Do you have any r	ashes, pres	sure sores,	or other skin		
3.			ently takir ne counte			on or nonpr	escrip-	Ш	Ш		29	problems? Have you had a he	ernes skin in	fection or co	old sore?	П	
4.	Do you	ı hav	e allergie			pollens, fo	ods or				30.	Have you ever had	d a head inju	ry or concu	ssion?		
5.	stingin	_		ad out o	yr noarly i	passed ou	+ DI ID.				31.	Have you been hit		d and been	confused or		
J.	ING ex			su out c	л пеапу г	Jasseu ou	יוסטוו-				32.	lost your memory? Have you ever had					
6.			-	sed or	it or nea	arly pass	ed out				33.	Do you have head	aches with				
7.	AFTER Have v			scomfo	rt. pain. o	r pressure	in vour	П	П		34.	Have you ever had your arms or legs a					Ш
	chest of	durin	g exercise	e?	•		-	_	_		35.	Have you ever bee	en unable to				
8.	Does exercis	-	ir heart	race	or skip	beats o	during	Ш	Ш		36	after being hit or fa When exercising in		vou have se	avere muscle	П	
9.	Has a	doct	or ever to		hat you h	ave					00.	cramps or become		, you have o	overe masore	Ш	
			nat apply) od pressu		Δ heart i	murmur					37.	Has a doctor told ye has sickle cell trait			n your family		
			olesterol		A heart i						38.	Have you had any			s or vision?		
10. Has a doctor ever ordered a test for your heart?									Do you wear glass								
(for example, ECG, echocardiogram) 11. Has anyone in your family died for no apparent								40.	Do you wear prote face shield?	ective eyewe	ar, such as	goggies or a	Ш				
reason?									Are you happy with								
12. Does anyone in your family have a heart problem?13. Has any family member or relative died of heart prob-				H				Are you trying to g Has anyone recom			ur weight or	Н	Н				
lems or of sudden death before age 50?									eating habits?				Ш				
14. Does anyone in your family have Marfan syndrome?					Ш	Ш			Do you limit or car Do you have any co								
15. Have you ever spent the night in a hospital?								40.	with a doctor?	oncerns that	you would iii	NE to discuss	Ш	Ш			
16.	Have y	ou e	ver had s	urgery?				ă		•	FEN	MALES ONLY					
17. Have you ever had an injury, like a sprain, muscle or									46.	Have you ever had How old were you	d a menstrua	al period?	manatrual				
						ed you to					47.	period?	wrien you r	iau your iirsi	menstrual		
18.						ed area be tured bo					48.	How many perio	ds have y	ou had in	the last 12		
	disloca	ited j	oints? If y	es, circ	le below			_				months?					
19.	Have y	ouh: CT.s	ad a bone urgerv. in	or joint jection:	injury tha s. rehabi	it required litation, p	x-rays, hvsical	Ш	Ш		Expi	ain "Yes" answers he	ere:				
	therap	y, a				es? If yes											
	below:		0, 1,		F.,	_	,										
Head	d Ne	CK	Shoulder	Upper arm	Elbow	Forearm	Hand/ fingers	Che	ST								
Uppe back			Hip	Thigh	Knee	Calf/shin	Ankle	Foo	t/toes								
20.	Have v	ou e	ver had a	stress t	fracture?			П									
20. Have you ever had a stress fracture?21. Do you regularly use a brace or assistive device?																	
22. Has a doctor ever told you that you have asthma or allergies?					Ш	Ш											
23. Do you cough, wheeze, or have difficulty breathing								_									
during or after exercise? 24. Is there anyone in your family who has asthma?																	
25. Have you ever used an inhaler or taken asthma																	
11	medici		at to the h	est of m	v knowled	de my anev	vers to th	ne ah	OVE C	lestion	15 21	e complete and correc	et .				$\overline{}$
	anature o			COL UI III	y KIIOWICU	ge, my ansv	•513 tO U	ie au				e complete and correc	,		Date		

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PHYSICAL EXAMINATION FORM

Name	First		Birthda	ate	SSN#			
HtWtSport	(s)			_Pulse	B/P / _	(/	,	_/)
Vision R 20/ L 20/	Corrected	☐ Yes	□No	Pupils: Equal_		_ Unequal		
Follow-Up Question 1. Do you feel stressed 2. Do you ever feel so s 3. Do you feel safe? 4. Have you ever tried of 5. During the past 30 da 6. During the past 30 da 7. Have you ever taken 8. Have you ever taken Notes:	out or under a lot of ad or hopeless that sigarette smoking, e ays, did you use che ays, have you had a steroid pills or shots any supplements to	f pressure you stop ven 1 or 2 ewing tob t least 1 o s without b help you	e? o doing sor 2 puffs? D acco, snu drink of alc a doctor's u gain or lo	o you currently sm ff, or dip? cohol? s prescription? ose weight or impro	oke?		Yes	No
	Normal			Abnormal Findi	nas/Notes			
MEDICAL	110111101							
Appearance								
Eyes/Ears/Nose/Throat								
Lymph Nodes								
Heart								
Pulses								
Lungs								
Abdomen								
Genitalia (males only)								
Skin								
MUSCULOSKELETAL	•							
Neck								
Back								
Shoulder/Arm								
Elbow/Forearm								
Wrist/Hand/Fingers								
Hip/Thigh								
Knee								
Leg/Ankle								
Foot/Toes								
LABS/TESTS (if appropria	rte)							
Hgb/Hct								
Ferritin								
Sickle Cell								
Name of Physician (print/ty	pe):							
Address:					Phone	<u> </u>		

Signature of Physician______, MD or DO Adapted from @2004 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

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OL.					IVI

Name	Sex	Age	Date of birth	_
☐ Cleared without restriction				
\square Cleared, with recommendation for further eva	aluation o	r treatment for:		_
				_
				_
\square Not cleared for: \square All sports \square Certain sport	:s:		Reason:	_
Recommendations:				_
				_
EMERGENCY INFORMATION				
Allergies				_
Other information				
IMMUNIZATIONS (eg, tetanus/diptheria/pertus	sis; measl	es, mumps, rubella	; hepatitis A, B; influenza; poliomyelitis;	
pneumococcal; meningococcal; varicella)				
\Box Up to date (see attached documentation) \Box	Not up to	date Specify		
Name of Physician (print/type):			Date:	_
Address:			Phone:	_
Signature of Physician			, MD or D0	Э

Adapted from @2004 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.