

Preparticipation Physical Examination for COC Intercollegiate Athletes

HISTORY _____

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of Birth _____
 1st season or 2nd season (circle) Sport(s) _____
 Address _____ Cell # _____
 Personal Physician _____

In case of emergency, contact
 Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers below.
 Circle questions you don't know the answers to.

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or Injury since your last check up or sports physical?
Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?
Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?
Have you ever been dizzy during or after exercise?
Have you ever had chest pain during or after exercise?
Do you get tired more quickly than your friends do during exercise?
Have you ever had racing of your heart or skipped heartbeats?
Have you had high blood pressure or high cholesterol?
Have you ever been told you have a heart murmur?
Has any family member or relative died of heart problems or of sudden death before age 50?
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head Injury or concussion?
Have you ever been knocked out, become unconscious, or lost your memory?
Have you ever had a seizure?
Do you have frequent or severe headaches?
Have you ever had numbness or tingling in your arms, hands, legs, or feet?
Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 9. Do you cough, wheeze, or have trouble breathing during or after activity?
Do you have asthma?
Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 11. Have you had any problems with your eyes or vision?
Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 12. Have you ever had a sprain, strain, or swelling after injury?
Have you broken or fractured any bones or dislocated any joints?
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <i>If yes, check appropriate box and explain below:</i> | | |
| | | | <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip | | |
| | | | <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh | | |
| | | | <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee | | |
| | | | <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/calf | | |
| | | | <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle | | |
| | | | <input type="checkbox"/> Upper arm <input type="checkbox"/> Foot | | |
| | | | 13. Do you want to weigh more or less than you do now?
Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 14. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 15. Record the dates of your most recent immunizations (shots) for:
Tetanus _____ Measles _____
Hepatitis B _____ Chickenpox _____ | | |
| | | | FEMALES ONLY | | |
| | | | 16. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____ | | |
| | | | Explain "Yes" answers to questions 1-16 here:

_____ | | |

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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PHYSICAL EXAMINATION

Name _____	Date of birth _____
Height _____	Weight _____
Pulse _____	BP _____ / _____ (_____ / _____, _____ / _____)
Vision R 20/ _____	L 20/ _____
Corrected: Y N	Pupils: Equal _____ Unequal _____

NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip (thigh)		
Knee		
Leg/ankle		
Foot		

*Station-based examination only

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____

CONSENT TO TREAT

The undersigned athlete/patient hereby consents to and authorizes any physician, athletic trainer, or medical personnel to administer and perform any and all medical examinations, treatments, designated procedures, and dispense medication which may be now or during the course of the athlete/patient's care as an outpatient be deemed advisable or necessary.

The undersigned also consents to the release of medical information to other institutions accepting the athlete/patient for medical care relative to continuity of the care for this visit. A photo static copy of this authorization shall be considered as effective and valid as the original.

Athlete/Patient Signature _____ Date _____