PRE-PARTICIPATION PHYSICAL FORM

Report of Medical History

Last Name:	First Name:	Middle Name:	❒ Male ❒ Female
Home Address:		City, State, Zip	
Name/Relationship of Person to Contact in case of emergency:			Phone:
Address (if other than above)		City, State, Zip	

FAMILY HISTORY

	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Have any of your relatives ever had any of the following:

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

PERSONAL HISTORY *Please answer all questions. Comment on all positive answers in the space below or on a separate sheet.*

Have you had:	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Typhoid			High/Low Blood Pressure			Rupture Hernia		
Measles			Polio			Rheumatic Fever/Heart Murmur			Recent Gain/Loss of Weight		
German Measles (Rubella)			Pain/Pressure in Chest			Disease or Injury of Joints			Dizziness, Fainting		
Mumps			Chronic Cough			“Trick” Knee, shoulder, etc.			Weakness, Paralysis		
Chicken Pox			Surgery:			Back Problems			Venereal Disease		
Malaria			Appendectomy			Tumor, Cancer, Cyst			Albumin/Sugar in Urine		
Gum/Tooth trouble			Tonsillectomy			Jaundice			Frequent Urination		
Sinusitis			Hernia Repair			Stomach/Intestinal Trouble			**FEMALES ONLY**		
Eye Trouble			Other			Gallbladder Trouble/Gallstones			Irregular Periods		
Ear, Nose, Throat Trouble			Palpitations (heart)			Recurrent Diarrhea			Severe Cramps		
CLARIFY ALL POSITIVE ANSWERS:									Excessive Flow		

	YES	NO
A. Has your physical activity ever been restricted during the past five years? (Give restrictions and durations)		
B. Have you had difficulty with school studies, or teachers? (Give details)		
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (give details)		
D. Have you had any illness or injury or been hospitalized other than already noted? (give details)		
E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (other than routine checkups)		

ADDITIONAL COMMENTS:

To the best of my knowledge, this information is accurate.

Date Student’s Signature

Physician’s Signature (acknowledging review)

REPORT OF HEALTH EXAMINATION/EVALUATION
(To be completed by a Physician)

Name: ____________________

Height: ____________ Weight: ____________ BP: ______ / ______

❒ CORRECTED VISION: right 20/ ____________ left 20/ ____________

Are there any abnormalities of the following systems? If yes, state diagnosis and treatment in space below.

	Yes	No		Yes	No
A. Head, Ears, Nose or Throat			G. Genitourinary		
B. Respiratory			H. Musculoskeletal		
C. Cardiovascular			I. Metabolic/Endocrine		
D. Gastrointenstinal			J. Neurological		
E. Hernia			K. Psychiatric		
F. Eyes			L. Skin		

CLARIFY ALL POSITIVE ANSWERS:

Is the patient now under treatment for any medical condition?

❒ Yes ❒ No Please explain condition and treatment:

Recommendations for participation in intercollegiate athletics:

❒ Unlimited ❒ Limited Please explain if limited:

Physician's Name (PRINTED) *LICENSE #*

Address *City, State & Zip* *County*

Date *Physian's Signature*