



## PARK UNIVERSITY ATHLETIC TRAINING EDUCATION PROGRAM

### Pre-participation Physical Form

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Local Phone (including area code)

\_\_\_\_\_  
Student ID Number (if applicable)

*All information will remain confidential unless written permission obtained from you to release information.*

**Please answer the following questions and give details below.**

Please indicate accurate responses	Yes	No
Have you been hospitalized?		
Have you had surgery?		
Have you had an injury or illness in the past year?		
Have you had injury or illness since your last exam?		
Have any chronic or recurrent medical problems?		
Had a concussion, head injury resulting in unconsciousness?		
Been hospitalized due to a head injury?		
Been medically disqualified from sports participation?		
Experienced heat illness: exhaustion, stroke, cramps?		
Have a pin, screw or plate in your body?		
Have a history of anemia?		
Have any injuries (fractures, sprains, dislocations) to your:		
Neck		
Back		
Abdomen		
Ribs/Chest		
Shoulder		
Elbow		
Arm		
Hand/Fingers/Thumb		
Hip/Pelvis		
Upper, Middle or Lower Back		
Thigh		
Knee		
Ankle		
Foot/Toes		

Please indicate accurate responses	Yes	No
Convulsions, seizures, epilepsy		
Frequent or chronic cough		
Diabetes		
Fainting or severe dizziness		
Gastrointestinal disorders or ulcer		
Frequent or severe headaches		
Asthma or shortness of breath		
Chest pain, dizziness, shortness of breath during or after exercise		
Hearing problems		
Heart problems (murmur, irregular beat)		
Hernia or rupture		
High or low blood pressure		
Injury to a kidney, testicle, eye, spleen		
Rheumatic fever		
Skin disorders (dermatitis, rashes)		
Tuberculosis		
Pneumonia		
Kidney disease or infection		
Liver disease (mononucleosis, etc.)		
Viral diseases (hepatitis, HIV, etc.)		
Bleeding disorders		
Had any nerve injuries, burners, stingers, sciatica		
Had a sudden death of a family member under the age of 50 of non-accidental causes		
Allergies to be stings, foods, or other substances		
Have you ever had anorexia nervosa, bulimia, or compulsive eating behavior		
Sickle cell trait		

Comments:

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Please indicate accurate responses	Yes	No	Please Explain
Are you allergic to any medications?			If so, what?
Are you taking any prescribed medications (i.e. birth control pills, anti-inflammatory, antibiotics)			If so, what?
Do you wear glasses or contacts during competition?			What type?
Do you wear any devices, such as orthotics, braces, dentures, hearing aids?			What type?

Females Only	Yes	No	Please explain:
Do you have irregularity, pain, unusual bleeding or absence of menstrual cycles?			
When was your most recent pelvic exam?			Date:
Are you pregnant?			
Do you take birth control pills or hormone replacements?			

To be completed by a clinician (AT or other)	
Heart Rate	BPM
Blood Pressure	
Urinalysis	

Height	Inches
Weight	lbs.

**PHYSICAL EXAM (MD, DO, PA, NP only)**

Musculoskeletal Exam	Nor	Abn
Spine (Symm, ROM)		
Shoulder (Symm, ROM)		
Elbow (Symm, ROM)		
Wrist/Hand/Fingers (Symm, ROM)		
Ribs (Symm, ROM)		
Hips/Pelvis (Symm, ROM)		
Knees (Symm, ROM)		
Ankles/Feet/Toes (Symm, ROM)		

General	Nor	Abn
E, E, N, T		
Dental		
Neck		
Skin		
Heart		
Lungs		
Breasts		
Abdomen		
Groin		
Genitals		
Hernia		

**STATUS** (Please Check One)

Cleared Unrestricted	
Cleared Restricted (please explain below)	
Not Cleared (please explain below)	

**REQUIRES** (If Applicable)

Further Evaluation	
Medical Records	
Follow-Up (please explain below)	

Comments:

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Signature (MD, DO, PA, NP only)

Date