Preparticipation Evaluation

Houghton College Athletics

Name:_____ DOB: _____ Date of Exam: _____

Age: _____ Gender: _____ Current school yr (circle): First-year Sophomore Junior Senior

Sport (s): _____

MEDICAL HISTORY			
GENERAL QUESTIONS:	Yes	No	Explain "yes" answers here…
Do you have any ongoing/chronic medical conditions?			
Have you ever spent the night in the hospital?			
Have you ever had surgery?			
Do you see a specialist for any reason?			
Do you take any prescription medications? (If so, please list…)			
Do you take any OTC meds/supplements regularly? (If so, please list…)			
Do you have any allergies to medications? (If so, please list…)			
Do you have any other allergies?			
Do you use tobacco in any form (cigarettes, chew, etc.)?			
Do you drink alcohol?			
Do you use any performance enhancing substances?			
Do you use any other drugs?			
Do you wear eyeglasses or contacts?			
CARDIAC QUESTIONS:	Yes	No	Explain "yes" answers here…
Have you ever passed out during or after exercise?			
Have you ever been dizzy during or after exercise?			
Have you ever had chest pains during or after exercise?			
Have you ever been unusually short of breath with exercise?			
Have you ever had racing of your heart or "skipped beats?"			
Do you get tired more quickly than your friends/teammates?			
Have you ever been told you have a heart murmur?			
Have you ever had high blood pressure?			
Have you ever had any tests done for your heart? (e.g. ECHO or EKG)			
NEUROLOGIC QUESTIONS:	Yes	No	Explain "yes" answers here…
Have you ever been diagnosed with a concussion?			
Have you ever had a head injury that caused confusion, prolonged headache, or memory problems?			
Have you ever had seizures or been diagnosed with epilepsy?			
Do you get frequent headaches or have a chronic headache syndrome?			
Does exercise ever cause you to have headaches?			
Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?			
ORTHOPEDIC QUESTIONS:	Yes	No	Explain "yes" answers here…
Have you ever had a broken bone, stress fracture or joint dislocation?			
Have you ever had a ligament sprain requiring medical treatment?			
Have you ever had a severe joint injury or surgery on a joint?			
Have you ever been referred to an orthopedic specialist for a joint injury?			
Have you ever been referred to physical therapy for a joint injury?			
Have you ever had an activity-limiting back injury or back pain?			
Have you ever had an activity-limiting neck injury or neck pain?			
Do you use any special braces, orthotics or other protective equipment?			
COVID-19 QUESTIONS:			
Have you had COVID-19?			
If yes, please provide the date of the positive test			
Have you received the COVID19 vaccination?			
If yes, please provide type and date/s of vaccine:			

Physician initials:

OTHER MEDICAL QUESTIONS:	Yes	No	Explain "yes" answers here…
Do you cough, wheeze or have breathing difficulty during/after exercise?			
Have you ever been diagnosed with asthma?			
Have you ever used an inhaler for breathing problems?			
Have you ever developed hives during exercise?			
Have you ever had a hernia or noticed a bulge in your groin?			
Have you ever had a herpes or MRSA skin infection?			
Do you currently have a rash or any open sores?			
Have you been diagnosed with mono within the last month?			
Have you ever become ill while exercising in the heat?			
Do you frequently get muscle cramps while exercising?			
Have you had any eye injuries or other problems with your eyes/vision?			
Are you concerned that you weigh too much?			
Are you concerned that you weigh too little?			
Are you on any special diet, or do you avoid certain types of foods?			
Have you ever been treated for or diagnosed with an eating disorder?			

FOR FEMALES ONLY:		Comments…
How old were you when you had your first menstrual period?		
When was your most recent menstrual period?		
How many periods have you had in the last 12 months?		

FOR MALES ONLY:	Yes	No	Explain "yes" answers here…
Have you noticed any testicular/scrotal lumps that you are concerned about?			

MENTAL HEALTH QUESTIONS:	Yes	No	Explain "yes" answers here…
Have you ever been diagnosed with depression?			
Have you ever been diagnosed with anxiety?			

Over the last TWO weeks, how often have you been bothered by…	Not at all	Several Days	More than Half	Nearly Every Day	
Little interest or pleasure in doing things	0	1	2	3	
Feeling down depressed or hopeless	0	1	2	3	
Feeling nervous, anxious or on edge	0	1	2	3	
Not being able to stop or control worrying	0	1	2	3	

FAMILY HISTORY: Has anyone in your family had/been diagnosed with…	Yes	No	Explain "yes" answers here…
Premature death (before the age of 50)?			
Marfan Syndrome?			
Congenital heart problems			
Pacemaker or defibrillator			
Unexplained fainting or seizures			
Asthma			
Sickle cell trait or disease			

CONCLUDING QUESTIONS:	Yes	No	Explain "yes" answers here…
Has a doctor ever denied or restricted your participation in sports for any reason?			
Do you have any concerns that you would like to discuss with your health care provider?			

Physician initials:

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

Student signature: _____ Date: _____

Parent/guardian signature (if a minor): _____ Date: _____

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PHYSICAL EXAMINATION:

VITALS:

Height:_____ Weight: _____ BMI: _____ Pulse: _____ BP: _____/_____ (_____/_____)
Vision (corrected): Right 20/ Left 20/

MEDICAL SCREENING EXAM:	Normal	Abnormal	Comments
Appearance (Marfan's stigmata?)			
Ears and Nose			
Eyes/Pupil symmetry (equal?)			
Oropharyngeal cavity			
Lymph nodes (AC, PC, supraclavicular…)			
Heart (standing and lying…)			
Pulses (especially femoral and radial…)			
Lungs			
Abdomen			
Skin			
Neuro			
Genitourinary/hernia (males only)			

ORTHOPEDIC SCREENING EXAM:	Normal	Abnormal	Comments
Neck			
Back			
Shoulders/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg			
Ankle/foot			
Functional test (duck walk)			

Assessment: ☐ Generally healthy athlete ☐ No acute issues ☐ Chronic conditions are stable
Comments:

Clearance:

☐ Cleared without restriction.
☐ Cleared without restriction, with recommendation for further evaluation/treatment for ….
_____ _____
☐ Cleared with restrictions…as outlined…
_____ _____
☐ Clearance pending, requires documented follow-up of …
_____ _____
☐ Not cleared, due to ….
_____ _____

Comments:

Physician/provider signature:_____ Date:_____
Physician/provider name: _____