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|  | THE UNIVERSITY OF WEST ALABAMA | REVISED 07/15/18 |
| MEDICAL HISTORY & PRE-PARTICIPATION |  |
| ***PHYSICAL EXAMINATION FORM*** | DATE: |  | / |  | / |  |  |
| Athlete’s |  |  | Month |  | Day |  | Year |  |
| Name: |  | Sports(s): |  |
|  | (Last) (First) (Middle) (Nickname) |  |  |
| Social |  |  |  |
| Security No: |  | / |  | / |  |  |  | Date of Birth: |  | / |  | / |  |  |  | / |  | / |  |
|  |  |  |  |  |  |  |  | Month |  | Day |  | Year |  | Age |  | Sex |  | Race |
| Student No: |  |  |  | Classification: | Fr. So. Jr. Sr. Red Shirt Sr. |  |
|  | (Different than Social Security No.) |
|  |  |   | e-Mail Address(es): |  |
| Local Apartment, Address, Dormitory, etc. |  | Local Phone: |  | Cell Phone: |  |
|  |
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| --- | --- | --- | --- |
| **I. Person to notify in case** **of an Emergency:** |  | Relationship: |  |
| Address: |   |
|  | (City) (State) (Zip)  |
| Home Phone:  | ( |  | ) |  | Business Phone: | ( |  | ) |  |
| Cell Phone | ( |  | ) |  | e-Mail: |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **II. Marital Status** **(if applicable)** | S | M | W | D | Separated |  | Spouse’sName: |  |
| Address: |  | e-Mail: |  |
|  | (City) (State) (Zip) |  |
| Home Phone: | ( |  | ) |  | Business Phone: | ( |  | ) |  | Cell Phone: | ( |  | ) |  |

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|  **III. Name of family physicians:** |  | Business Phone | ( |  | ) |  |
| Address: |  |
|  | (City) (State) (Zip) |

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**INTERIM MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| 1. Have you had any serious illness, disease, injury, operation, mental illness, infection, accident, or any other significant medical conditionduring the past year (12 months)? If yes, please explain. | **YES** | **NO** |
|  |
| 2. Did this medical condition or any other medical condition require surgery? If yes, please explain, including date & location. | **YES** | **NO** |
|  |
| 3. Have you been hospitalized or examined by a physician other than the team physician for any type of medical condition during the past year (12 months)? If yes, for what reason? | **YES** | **NO** |
|  |
| 4. Have you been out of the United States within the last three (3) months? If yes, give an explanation. | **YES** | **NO** |
|  |
| 5. Have you had a concussion during the past year (12 months) that was not evaluated by our team physician? If yes, give an explanation, including dates & location. | **YES** | **NO** |
| 6. Have you had any immediate relative die suddenly in the past year (12 months)? If so, what was the cause of death? | **YES** | **NO** |
| 7. During the past year (twelve months) have you had any type of problem(s) with tolerance to exercise? If yes, please give a brief explanation. | **YES** | **NO** |

If you have any additional conditions, problems, or comments that have not been addressed thoroughly in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our best medical care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

**DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRINTED NAME OF ATHLETE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(First) (Middle) (Last)**

**DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF ATHLETE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STOP HERE!**

Please do not complete anymore. The remainder of this form is for the athletic training & sports medicine staff to complete.





**Pre-Participation Physical Examination Form**

|  |
| --- |
| HEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT: \_\_\_\_\_\_\_\_\_\_\_ BODY COMPOSITION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_% \_\_\_\_\_\_\_\_\_\_\_ (Formula) |
| INJURED DURING LAST 12 MONTHS \*\*\*(Record any ROM Limitations, Deformities, Abnormalities)\*\*\* |
| **NECK**: No, Yes | **SPINE**: No, Yes  |
| **SHOULDER**: R): No, Yes L): No, Yes  | **WRIST**: R): No, Yes L): No, Yes |
| **ELBOW**: R): No, Yes L): No, Yes | **HANDS & FINGERS**: R): No, Yes L): No, Yes |
| **HIP**: R): No, Yes L): No, Yes | **KNEE**: R): No, Yes L): No, Yes |
| **ANKLE**: R): No, Yes L): No, Yes | **FEET & TOES**: R): No, Yes L): No, Yes |
| **HAMSTRING:** L)\_\_\_\_\_\_\_\_\_\_ (degrees) R)\_\_\_\_\_\_\_\_\_\_ (degrees) **DORSIFLEXION:** L)\_\_\_\_\_\_\_\_\_\_ (degrees) R)\_\_\_\_\_\_\_\_\_\_ (degrees) |
| **VISUAL ACUITY:** L)\_\_\_\_\_\_\_\_\_\_ R)\_\_\_\_\_\_\_\_\_\_(corrected or uncorrected) DOMINANCE: EYE\_\_\_\_\_\_\_\_\_ HAND\_\_\_\_\_\_\_\_\_Contacts:\_\_\_\_\_\_\_\_\_\_\_\_ Glasses:\_\_\_\_\_\_\_\_\_\_\_\_ Are they worn during athletic participation? Yes No |
| GENERAL MEDICAL: |
| **BLOOD PRESSURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PULSE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | **NORMAL** | **ABNORMAL** |  | **NORMAL** | **ABNORMAL** |
| HEAD |  |  | RESPIRATORY |  |  |
| EYES |  |  | HEART |  |  |
| EAR, NOSE, THROAT |  |  | ABDOMEN |  |  |
| NECK |  |  | URINARY |  |  |
| SKIN |  |  | OTHER |  |  |
| Physicians Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DENTAL: |
| **URINALYSIS:** | Glucose | Bilirubin | Ketone | SG | Blood | Ph | Protein | Urobilinogen | Nitrate | Leukocytes |
|  |  |  |  |  |  |  |  |  |  |  |

OVERALL PHYSICAL EXAMINATION RESULTS:

|  |  |  |
| --- | --- | --- |
| RESULTS | **CHECK ONE** | **COMMENTS** |
| PASSED WITHOUT LIMITATIONS |  |  |
| **PASSED PENDING THE FOLLOWING:** |  |  |
| **FAILED DUE TO THE FOLLOWING:** |  |  |
| **At this date, I can find no physical abnormality that would deter this student from fully participating in all of the sports listed below, except the ones that are circled:** | Badminton, Baseball, Basketball, Cheerleading, Cross Country, Football, Golf, Rodeo, Soccer, Softball, Swimming, Tennis, Track & Field, Volleyball, Weight Training, Wrestling |

**Physician's Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician's Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_