



Muhlenberg College Health Services Participation Physical Evaluation

History Form

To Be Completed By Athlete:

Sport(s): _____ Date: _____

Name _____

Home Address: _____ Last _____ First _____ City _____ State _____ Zip _____ M. I. _____

Birthdate _____ Age: _____ Class: _____ Campus Phone: _____ Cell Phone: _____

Parent/Guardian Name: _____ Phone: (H) _____ (W) _____

Emergency Contact: _____ Relationship: _____ Phone: _____

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

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any ongoing medical conditions? (like diabetes or asthma) | <input type="checkbox"/> | <input type="checkbox"/> | 25. Is there anyone in <i>your</i> family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insect. | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | | 32. Have you been hit in the head and been confused or lost <i>your</i> memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart infection | | | 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for <i>your</i> heart? (for example, ECG, Echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> | 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |

- FEMALES ONLY**
47. Have you ever had a menstrual period? Yes No
48. How old were you when you had your first menstrual period? _____
49. How many periods have you had in the last year? _____

Explain "Yes" answers here:

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>					
21. Have you been told that you have or have you had an <i>x-ray</i> for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>					
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>					
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>					

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 _____

Printed Name of Athlete _____ Printed Name of Parent/ Guardian _____ (Athlete under 18 years of age)

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Rev. 3/06.



**Muhlenberg College Health Services
Participation Physical Evaluation**

Physical Examination Form

To Be Completed By Physician:

Name _____ DOB _____

Height: _____ Weight: _____ Pulse: _____ BP: _____ / _____

Vision: R 20/ _____ L20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

Follow-Up Questions on More Sensitive Issues

	Yes	No
1. Do you feel stressed out or under a lot of pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel safe?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
5. During the past 30 days did you use chewing tobacco, snuff or dip?	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past 30 days have you had at least 1 drink of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever taken steroids without a doctor's prescription?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever taken any supplements to help you gain or lose weight or improve performance?	<input type="checkbox"/>	<input type="checkbox"/>

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary/Testicles		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

Cleared without restriction

Cleared, with recommendations for further evaluation of treatment for:

Not cleared for All sports Certain sports: _____ Reason: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO



**Muhlenberg College Health Services
Participation Physical Evaluation**

Medical Clearance Form

Name _____ Sex _____ Age _____ Date of Birth _____

EMERGENCY INFORMATION

Allergies: _____

Other Information: _____

To Be Completed by Student Athlete

The undersigned herewith:

1. Understands that the above information will be reviewed by the Health Center staff, who will determine the athlete's ability to fully participate in athletics. The athlete may not participate until such time medical clearance is *granted*.
2. Understands that he/she must refrain from practice or play while ill or injured, whether or not receiving medical treatment and during medical treatment, until he/she is discharged from treatment or is given permission by the physician/athletic trainer to restart participation despite continuing treatment.
3. Understands that having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find medical reason to disqualify him/her at the time of said examination.
4. Certifies that the answers to the questions above are correct and true.

Signature of Student Athlete _____ Date _____

Printed Name of Student Athlete _____

**Please submit entire Participation Physical Evaluation Form (all three pages) to:
Muhlenberg College Health Services, 2400 Chew Street, Allentown, PA 18104, Telephone 484-664-3199, Fax 484-664-3522**