SAC STATE
SPORTS MEDICINE

Pre-Participation Medical History

Patient: _____ **Birthdate: _____** **Student ID#:_____**

Medicine and Allergies. Please list all prescription and over-the-counter medicines and supplements (herbal and nutritional) you are currently taking:
_____

Do you have any allergies (Medicines, Pollens, Foods, or Insects): ☐ Yes ☐ No If yes please specify: _____

Indicate if you have an EPIPEN for allergic reactions: ☐ Yes ☐ No Do you carry it on your person? ☐ Yes ☐ No

Do you or anyone in your family have Sickle Trait or Disease: ☐ Yes ☐ No If yes please specify: _____

GENERAL QUESTIONS	YES	NO	MEDICAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?			22. Do you cough, wheeze or have difficulty breathing during or after exercise?		
2. Do you have an ongoing medical condition? ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other _____			23. Were you born without or are you missing a kidney, an eye, a testicle (male at birth), spleen, or any other organ?		
3. Have you ever spent the night in the hospital?			24. Do you use Asthma medication?		
4. Have you ever had surgery?			25. Do you have pain, a bulge or hernia in the groin area?		
HEART HEALTH QUESTIONS ABOUT YOU			26. Have you had Mononucleosis within the last month?		
5. Have you ever passed out or nearly passed out *DURING* or *AFTER* exercise?			27. Do you any rashes, pressure sore or other skin problems?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			28. Have you ever had a head injury or concussion? If yes, how many diagnosed concussion(s)?_____		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			29. Have you ever had a hit/blow to the head that caused confusion, prolonged headache or memory problems?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High Blood Pressure ☐ High Cholesterol ☐ A Heart Murmur ☐ Other _____			30. Do you have headaches with exercise?		
9. Has a doctor ever ordered a test for your heart? (ECG/EKG, Echocardiogram)			31. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
10. Do you get light-headed or feel shorter of breath than expected during exercise?			32. Have you ever been unable to move your arms or legs after being hit or falling?		
11. Have you ever had a seizure?			33. Have you ever become ill while exercising in the heat?		
12. Do you get more tired or short of breath more quickly than friends during exercise?			34. Do you get frequent muscle cramps when exercising in the heat?		
13. Has any family member or relative died of heart issues or had an unexplained or unexpected death before the age of 50 (including droning or car accident)?			35. Have you had any eye injuries?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, Brugada syndrome, Long QT or Short QT syndrome, arrhythmogenic right ventricular cardiomyopathy, or catecholaminergic polymorphic ventricular tachycardia?			36. Do you wear protective eye wear, such as goggles or a face shield?		
15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?			37. Are you trying to, or has anyone recommended that you gain or lose weight?		
BONE AND JOINT QUESTIONS			38. Are you happy with your weight?		
16. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or competition?			39. Are you on a special diet or do you avoid certain types of foods?		
17. Have you ever had any broken or fractured bones or dislocated joints?			40. Do you have any concerns that you would like to discuss with a physician?		
18. Have you ever had an injury that required xrays, MRI, CT scan, injections, rehabilitation, a brace, a cast or crutches?			**People Assigned Female at Birth**	**YES**	**NO**
19. Have you ever had a stress fracture?			41. Have you ever had a menstrual period?		
20. Do you regularly use a brace, orthotics or assistive device?			If YES, how old were you when you had your first period?		
21. Do you have a bone, muscle or joint injury that bothers you?			If YES, how many periods have you had in the last 12 months?		
			42. Are you on contraception? Which one? _____		

Explain 'YES' answers from above here. Include question # and dates of issues in detail: _____
_____
_____

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 (If under the age of 18)_____ Date _____

_____

I have reviewed the questions and answers above. **Signature of Clinician _____ Date _____**

SAC STATE
SPORTS MEDICINE

Pre-Participation Physical Exam

Patient: _____ **Birthdate:** _____ **Sport Clubs:**

Student ID #: _____ **Phone #:** _____ **Email:** _____

Height	Weight	Internal Use Only	BP	Pulse	

NML	ABN	General Assessment	Comments
☐	☐	Head	
☐	☐	Eyes	
☐	☐	ENT	
☐	☐	Lungs	
☐	☐	Cardiovascular	
☐	☐	Abdomen	
☐	☐	GU (if indicated)	
☐	☐	Skin	
☐	☐	Neurological	

NML	ABN	Musculoskeletal Assessment	Comments
☐	☐	C-Spine	
☐	☐	Shoulders	
☐	☐	Elbows	
☐	☐	Wrists	
☐	☐	Hands	
☐	☐	Spine	
☐	☐	Hips	
☐	☐	Knees	
☐	☐	Ankles	
☐	☐	Feet	

Medical Eligibility:

□ Medically eligible for all sports without restriction

□ Medically eligible for all sports without restriction with recommendation for further evaluation or treatment of

_____

_____

□ Medically eligible for certain sports

_____

_____

□ Not medically eligible pending further evaluation (clearance to be reconsidered after evaluation completed)

□ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. A copy of the physical examination findings are on record in my office and can be made available at the request of the patient. If conditions arise after the athlete has been cleared for participation, the clinician (MD, DO, NP or PA) may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of Health Care Professional: _____ Date: _____

Address: _____ Phone: _____

Signature of Health Care Professional: _____, MD, DO, NP or PA