Sport:_____

PENN STATE ALTOONA
VARSITY ATHLETICS

Pre-Participation Physical Examination

Name:	PSU ID:	Date:
Date of Birth:	Sex:	Age:
List any allergies (animal, food, plants, medications):	List any medications (including prescription, OTC, herbs, supplements)	
Do you carry an EPI- PEN? ( ) Y ( ) N	Do you use an inhaler due to asthma? ( ) Y ( ) N	

The following questions are to be answered yes or no. Please check the appropriate box. (Comment on all "yes" questions.)

YES	**NO**	**Has anyone in your immediate family ever had:**	**Comments: (Who? and has the problem resolved?)**
( )	( )	Diabetes (high blood sugar)?	_____
( )	( )	Sudden death (age less than 50)?	_____
( )	( )	High blood pressure, high cholesterol?	_____
( )	( )	Heart attack (age less than 50)?	_____
( )	( )	Asthma? Wheezing/coughing with exercise?	_____
( )	( )	Sickle cell anemia/Sickle cell trait?	_____
( )	( )	Convulsions (seizures) or epilepsy?	_____
Have you ever had or do you now have:			
( )	( )	Sickle cell anemia/Sickle cell trait?	_____
( )	( )	Dizziness with or after exercise?	_____
( )	( )	High blood pressure?	_____
( )	( )	Racing of the heart/irregular rhythm?	_____
( )	( )	Wheezing/cough with exercise or asthma?	_____
( )	( )	Weakness, fatigue or anemia?	_____
( )	( )	Heart murmur? Heart condition?	_____
( )	( )	Marfan Syndrome	_____
Have you ever had:			
( )	( )	Loss of consciousness?	_____
( )	( )	Concussion? [If yes, year(s)]	_____
( )	( )	Convulsions (seizures) or epilepsy?	_____
( )	( )	Neck Injury? (If yes, year)	_____
( )	( )	"Stinger", "Burner", or "Pinched nerve"	_____
Have you ever:			
( )	( )	Been hospitalized for a medical problem? (If yes, year)	_____
( )	( )	Had infectious mononucleosis? (If yes, +blood test? Y/N)	_____
( )	( )	Had heat exhaustion or intolerance?	_____

NAME:_____

The following questions are to be answered yes or no. Please check the appropriate box. (Comment on all "yes" questions.)

Have you ever: (Give approximate date if "YES)			**Comments: (if answer Yes, please list date)**
YES	**NO**		
( )	( )	Been hospitalized or had surgery?	_____
( )	( )	Broken a bone?	_____
( )	( )	Had a muscle injury?	_____
( )	( )	Had a knee injury?	R ( ) L ( ) **ACL/PCL** [circle one]; R ( ) L ( ) **MCL/LCL** [circle one] R ( ) L ( ) meniscus
		If yes, is problem resolved?	_____
( )	( )	Had a shoulder injury?	R( ) L( ) **Rotator cuff** ; R ( ) L ( ) **labrum**
		If yes, is problem resolved?	_____
( )	( )	Had a back injury?	_____
		If yes, is problem resolved?	_____
( )	( )	Had any other joint injuries?	_____
		( ) Hip ( ) Elbow ( ) Wrist ( ) Foot ( ) Other_____	
( )	( )	Are you currently in physical therapy?	_____

Have you had or do you now have:			**Comments: (has the problem ever resolved?)**
YES	**NO**		
( )	( )	Hearing loss or perforated eardrum?	_____
( )	( )	Headaches or migraines?	_____
( )	( )	Dental plate or orthotic work?	_____
( )	( )	Impaired vision, wear glasses/contacts?	_____
( )	( )	Hernia?	_____
( )	( )	Loss of function or absence of testicle (males)?	_____
( )	( )	any form of CANCER? Type? Form of treatment?	_____
Have you in the past or do you currently use or have concerns about:			
( )	( )	Cigarettes, chewing tobacco or marijuana?	_____
( )	( )	Alcohol?	_____
( )	( )	Recreational drugs?	_____
( )	( )	Steroids?	_____
( )	( )	Vitamins or supplements?	_____
( )	( )	Wt. loss meds, laxatives, self-induced vomiting?	_____
( )	( )	eating disorder? Bulimia? Anorexia?	_____
Do you:			
( )	( )	Feel out of control when you are stressed?	_____
( )	( )	Have a history of depression or feel depressed?	_____
( )	( )	Wear a seat belt at least 90% of the time?	_____
( )	( )	Wear a bicycle/motorcycle helmet?	_____
( )	( )	Understand and regularly perform a self-breast exam?	_____
( )	( )	Understand and regularly perform a self-testicular exam?	_____
( )	( )	Practice safe sex? (abstinence, condoms)	_____
( )	( )	Have a history of > 2 sexual partners in the last 6 mths?	_____
( )	( )	Have a history of any sexually transmitted disease? (If yes, explain)	_____
( )	( )	Have any additional concerns or questions?	_____
FEMALES ONLY:			
( )	( )	Menstrual problems?	_____
( )	( )	Currently pregnant?	_____
( )	( )	Previous pregnancies?	_____
( )	( )	Vaginal discharge?	_____
( )	( )	Sexually transmitted infections?	_____
MALES ONLY:			
( )	( )	Penile discharge?	_____
( )	( )	Testicular mass or pain?	_____
( )	( )	Sexually transmitted infections?	_____

NAME:_____

Nutritional concerns:

What is your present weight? _____
Are you happy with your present weight? _____
If not, what is your desired weight? _____
How many meals do you eat each day? _____
Do you diet regularly? _____
Do you ever feel out of control of your eating patterns?_____
Have you ever tried to control you weight by:
Excessive exercise?_____ Vomiting?_____ Diet pills?_____ Laxatives?_____ Diuretics?_____
Have you ever had an eating disorder? _____

Mental Health concerns: Y for YES; N for NO

Do you currently take any medications for anxiety or depression? _____
Do you currently go to counseling? If yes, how often?_____
Do you ever feel that your worry/anxiety is out of control?_____
Do you feel sad or depressed more days than happy?_____
Do you abuse alcohol or drugs to help you cope with difficult or stressful situations?_____
Would you like to talk to someone to better manage your anxiety/depression?_____

ADHD

Do you currently take meds for attention deficit disorder?_( )Y ( ) N _____
If **YES**, please provide a current diagnosis from your prescribing medical doctor.
Many of the medications that are prescribed for ADHD are banned by the NCAA.
However, are allowed by student-athletes with proper documentation of drug name, dosage, doctor diagnosis, doctor signature, license number and facility name. This is additional paperwork that the student athlete must obtain.

DRUGS & SUPPLEMENTS

The NCAA bans the use of certain prescription drugs, OTC drugs, and supplements. It is your responsibility to report any use, addition or change of any substances. If you are unsure, please check with the certified athletic trainer and/or compliance director. If you are medically prescribed a banned substance, such as an inhaler, ADHD medication, or an epi-pen, you are allowed to take those drugs, but **MUST** have documentation from your MD prescribing the drug, along with the following information. Athlete name, date of birth, drug name, drug dosage, frequency of use, medical doctor name, license number and name of medical facility. Failure to provide this documentation could result in removal from sports participation and a positive drug test.

If any time during the school year I have medication or supplement additions or changes.
I, (sign name) _____will inform the athletic trainer. A current up to date medication list of medicines being taken, whether OTC or prescription and dosages needs to be on file with the athletic training staff at all times. Participation in Division III sports, means that student- athletes could be randomly drug tested.

I, _____, declare that all of the about information is true to the best of my knowledge.

Signature:_____ Date: _____

Signature of parent if < 18 yrs. Old_____ Date:_____

Updated 5/2017 JW

NAME: _____SPORT:_____

Physical Exam (To be completed by clinician)

Blood Pressure_____ Pulse_____ Height_____ Weight:_____

Vision R 20/_____ L 20/_____ corrected Y / N Pupil size: equal / unequal

Normal	**Abnormal**		**Comments**
( )	( )	HEENT	_____
( )	( )	Thyroid	_____
( )	( )	Lymphatics	_____
( )	( )	Cardiac	_____
( )	( )	Lungs	_____
( )	( )	Skin	_____
( )	( )	Abdominal	_____
( )	( )	Genitalia	Hernia? Y / N_____
( )	( )	Musculoskeletal:	
( )	( )	Neck	_____
( )	( )	Shoulder	_____
( )	( )	Elbow	_____
( )	( )	Wrist, hand	_____
( )	( )	Back	Scoliosis? Y / N_____
( )	( )	Knee	_____
( )	( )	Ankle, foot	_____
( )	( )	Neurologic	_____

Athlete educated that NCAA recommends all colleges and universities confirm the Sickle cell trait status of all student athletes.

Patient has:
1. Received screening:
   _____Results pending (to be sent to Sheetz HWC, 3000 Ivyside Park, Altoona, PA 16601)
   _____Results completed. NEGATIVE OR POSITIVE
2. _____Declined screening at this time.

I certify that I have reviewed the history and examined the above athlete, and based on this recommend sports activity:
1. _____Clearance with no limitations.
2. _____Clearance pending further evaluation or testing.
3. Referral to_____prior to clearance.
4. _____Clearance with limitations.
5. _____Disqualification from competition.

Signature of Examining Clinician (signature:_____ Date:_____

Print or stamp clinician's name, clinic name, address and phone number: (This must be filled out and legible)

_____
_____
_____

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