Pre-participation Physical Evaluation
University of Louisville Sports Medicine

Name:_____________________________ Sport: ______________ DOB: __________

Height:__________ Weight:_______ Pulse: _______ BP: _______

Vision: Right: 20/ ___ Left: 20/ ___ Corrected? YES NO

❑ Medical history form discussed with athlete

Laboratory testing ordered:
❑ Sickle cell trait (Mandatory for all athletes)
❑ Ferritin (all females & all male distance runners, others as ordered by physician)
❑ CBC (all females, others as ordered by physician)
❑ Other:________

MEDICAL	**Normal**	**Abnormal findings**	**Initials**
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Comments: ____

____

Based on medical history and physical examination, athlete is:
❑ Cleared without restrictions
❑ Cleared, with recommendation for further evaluation or treatment for: ______________________

____

❑ Not cleared Reason: ______________________________

Physician signature: ______________________ Date: __________

UofL Physician (PRINTED NAME): ____________________

UNIVERSITY OF LOUISVILLE SPORTS MEDICINE

STUDENT-ATHLETE MEDICAL HISTORY

Name: ________________________________ SPORT: ______________________ DOB: _________

To be completed by the student-athlete and reviewed by the Athletic Training Staff and Examining Team Physician.

Please answer the questions by placing an "X" in the blank or circling "YES" or "NO." Explain any "X" or "YES" answers to the questions in the space provided at the bottom of each page.

1. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

___ Asthma
___ Abnormal Heart Beat
___ Chest Pain
___ Diabetes
___ Frequent Headaches
___ Heart Murmur
___ Hernia
___ Heat Illness
___ Hepatitis
___ Concussion
___ Measles
___ Mononucleosis
___ High cholesterol
___ Seasonal Allergies
___ Seizures/Epilepsy
___ Sickle Cell Trait
___ Tuberculosis
___ Unusual Shortness of Breath
___ Rheumatic Fever
___ Stress Fracture
___ Inflammatory Bowel Disease (Crohn’s, Colitis)
___ Vocal Cord Dysfunction
___ Fainting/Passing Out
___ Attention Deficit Disorder (ADHD)
___ Other Significant Illnesses (explain below)

____
____
____
____

II. HAVE YOU EVER HAD AN INJURY INVOLVING THE FOLLOWING:

___ Head
___ Neck
___ Shoulder
___ Arm
___Elbow
___Wrist
___Head
___ Back
___ Chest/Breast
___ Ribs
___ Heart
___ Abdomen/Pelvis
___ Hip
___ Thigh
___ Knee
___ Calf
___ Ankle
___ Foot

EXPLAIN ANY INJURIES OR ILLNESSES WHICH WERE IDENTIFIED IN SECTIONS I and II

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____
____
____
____
____

I. CIRCLE THE APPROPRIATE ANSWER:

YES NO 1. Have you even been "knocked out" or experienced a concussion? If yes, how many? ______

Were you hospitalized for it? YES NO

YES NO 2. Have you ever had a "burner or "stinger?" If yes, how many? _____________

YES NO 3. Have you ever passed out or experienced dizziness from physical activity?

YES NO 4. Has your physical activity ever been limited due to a heart problem?

YES NO 5. Have you ever experience chest tightness or difficulty breathing from physical activity?

YES NO 6. Have you ever been withheld from participating in sports for a medical reason

YES NO 7. Do you wear glasses or contacts? Do you wear them while playing? YES NO

YES NO 8. Do you have any dead, missing or broken teeth?

YES NO 9. Do you wear any dental appliances, braces or dentures?

YES NO 10. Have you had any injuries to the neck or back nerves, vertebrae, or discs?

YES NO 11. Have you had any surgery on your back or neck?

YES NO 12. Do you experience any pain in your back?

YES NO 13. Have you ever ben told you injured the ligaments or cartilage in either knee?

YES NO 14. Do you experience a severe ankle sprain?

YES NO 15. Have you had any joint dislocations within the last 3 years?

YES NO 16. Have you had any fractures within the last 3 years?

YES NO 17. Have you had any surgeries with the last 3 years? Ever?

YES NO 18. Do you have any pins, plates or screws in your body to a bone or joint surgery?

YES NO 19. Are you allergic to any medications?

YES NO 20. Do you have any other allergies other than seasonal/environmental such as bee stings, latex or food

YES NO 21. Do you have a missing paired organ (kidney, testicles, eye, ovary, etc)?

YES NO 22. Does anyone in your family have Marfan's Syndrome?

YES NO 23. Have you ever spent the night in the hospital?

EXPLAIN ANY "YES" ANSWRS FROM SECTION III

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IV. ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR BREATHING

YES NO	1.	Does running ever cause chest tightness, coughing, wheezing, or long periods or shortness or breath?
YES NO	2.	Have you ever had difficulty performing in practice or competitions because of chest tightness, coughing, wheezing or long periods of shortness of breath?
YES NO	3.	Have you ever missed school, practice, or competition because of chest tightness, coughing, wheezing or long periods of shortness of breath?
YES NO	4.	Have you ever had difficulty performing in practice or competitions because of unusual fatigue?
YES NO	5.	Does being outside in the cold air cause chest tightness, coughing, wheezing, or long periods of shortness of breath?

V. DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

YES NO	Sudden cardiac death at a young age?	YES NO	Osteoporesis
YES NO	Heart disease or heart attack younger than 50 years of age?	YES NO	Alcohol or Drug Dependency
YES NO	Syncope (Passing out)?	YES NO	Diabetes?
YES NO	Sickle Cell Disease or Sickle Cell Trait?	YES NO	Stroke?
YES NO	High blood Pressure		

VI. FEMALES ONLY: MENSTRUAL HISTORY

Age of Onset: ______ Number of Periods in the last year: _________ Typical Duration of Periods (days): __________

Typical interval between periods (days): _______ Date of Last period: ________ Date of last pelvic exam/Pap Smear: _______

Do you require a medication for pain/cramps? YES NO If YES, What? ____________________________

Do you take birth control? YES NO If YES, What? ____________________________

Do you have any menstrual problems? YES NO Menstrual Flow: LIGHT AVERAGE HEAVY

Have you ever gone more than 3 months without a period? YES NO Have you ever been on birth control due to not having periods? YES NO

EXPLAIN ANY "YES" ANSWERS FROM SECTIONS IV -VI

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VII. COMPLETE THE FOLLOWING:

YES NO	1.	Are you happy with your weight?	If not, what is your desired weight? _______
YES NO	2.	Are you trying to gain or lose weight?	If yes: GAIN LOSE
YES NO	3.	Has anyone recommended you change your weight or eating habits?	
YES NO	4.	Do you limit or carefully control what you eat?	
YES NO	5.	Ever taken supplements to help you gain/lose weight, or improve your performance? If YES, List below	
YES NO	6.	Are you currently taking any supplements (including multi-vitamin)? If yes, list below:	

Supplement	*Reason*	*Dosage*	*How Often?*	*Currently Taking?*

7. Do you eat breakfast? NEVER RARELY SOMETIMES USUALLY ALWAYS

8. Rate your diet: POOR BELOW AVEREAGE AVERAGE GOOD EXCELLENT

9. In a typical day, how many meals and/or snacks do you have? MEALS __________ SNACKS ___________

10. Are you aware of any food allergies/intolerances you may have? (nuts, dairy, lactose, shellfish, etc.) ____________________

11. Have you ever received iron supplements? YES NO

How often do you consume the following?

Caffeine	NEVER	OCCAISIONALLY	OFTEN
Multivitamin	NEVER	OCCAISIONALLY	OFTEN
Fish Oil(Omega 3)	NEVER	OCCAISIONALLY	OFTEN
Alcohol	NEVER	OCCAISIONALLY	OFTEN
Creatine Supplements	NEVER	OCCAISIONALLY	OFTEN
Weight gain/loss supplements	NEVER	OCCAISIONALLY	OFTEN
Anti-inflammatory medications?	NEVER	OCCAISIONALLY	OFTEN

On average, how many hours of sleep do you get per night? Circle one:

4 hours or less 5-6 hours 6-7 hours 7-8 hours 8-9 hours

9-10 hours 10-11 hours 11 hours or more

Do you wish to see a nutritionist? YES NO If so, why? ____

VIII. ANSWER THE FOLLOWING QUESTIONS:

These answers will be kept confidential.

YES NO 1. Do you ever feel stressed out or under a lot of pressure?

YES NO 2. Do you have felt so sad or hopeless that you stop doing your normal activity for more than a few days?

YES NO 3. Do you feel safe?

YES NO 4. Do you currently smoke?

YES NO 5. During the past 230 days, have you used chewing tobacco, snuff, or dip??

YES NO 6. During the past 30 days, have you used marijuana, cocaine, heroin, ecstasy, or any other street drug?

YES NO 7. During the past 30 days, have you had a least 1 drink of alcohol?

YES NO 8 Have you ever taken steroid pills or shots without a doctor's prescription?

YES NO 9. Have you ever been in an abusive relationship or the victim of domestic violence?

YES NO 10. Do you own or have access to a gun or other weapon?

YES NO 11. Are you now, or have you ever been, under the care of a psychiatrist or psychologist?

EXPLAIN ANY "YES" ANSWERS FROM SECTION VIII.

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ADD/ADHA MEDICATION RECORDS

The NCAA bans classes of drugs because they can harm student-athletes and can create an unfair advantage in competition. Some legitimate medications contain n NCAA banned substances, and student-athletes may need to use these medicines to support their r academics and their general health. Effective August 2009 there will be a stricter application of the NCAA Medical Exception policy and specifically for the use of banned stimulant medications to treat Attention Deficit Disorder (ADD) and Attention Deficit t Hyperactivity Disorder (ADHD). The NCAA will require documentation that demonstrates the student athlete has undergone a clinical assessment to diagnose ADO and ADHD, is being monitored routinely y for use of the stimulant medication, and has a current prescription on file, in order to be approved for a medical exception to the banned drug policy. This documentation has to be kept on file in the University of Louisville Sports Medicine Department and produced in the event the student-athlete tests positive for the banned medication.

PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKING

Medication	*Reason*	*Dosage*	*How often?*

I verify that the information contained in this document is accurate and truthful to the best of my knowledge. I understand that any injury or illness not disclosed on this form will not be the responsibility of the University of Louisville Athletic Department. I further recognize that any injury or illness that has occurred prior to this form may not be the financial responsibility of the University of Louisville Athletic Department. I agree to provide that University of Louisville Sports Medicine Department with any changes or additions to this information as they become known to me.

____ ________________________

Student-Athlete Signature (or Parent/Guardian if under 18) Date