

Indiana Wesleyan University Pre-Participation Physical Evaluation

Name: _____ SS#: _____ Date: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Gender: _____ Age: _____ Date of birth: _____ Sport(s): _____

Personal Physician (& Location): _____

Previous School attended and dates: _____

Answer the following questions. Please explain "Yes" answers in the space provided below:

- | | | |
|--|---|---|
| 1. Have you ever been hospitalized? | Y | N |
| 2. Have you ever had surgery? | Y | N |
| 3. Are you presently under a doctor's care? | Y | N |
| 4. Are you presently taking or using any medications? | Y | N |
| 5. Are you presently taking any nutritional supplements? | Y | N |
| 6. Are you allergic to any medications? | Y | N |
| 7. Do you have an allergy to bee stings or insect bites? | Y | N |
| 8. Do you have any food or environmental allergies? | Y | N |
| 9. Have you even been dizzy during or after exercise? | Y | N |
| 10. Have you ever "passed-out" or collapsed during exercise? | Y | N |
| 11. Have you ever had chest pain during or after exercise? | Y | N |
| 12. Have you ever had high blood pressure? | Y | N |
| 13. Have you ever been told that you have a heart murmur? | Y | N |
| 14. Have you ever had a racing heart or skipped heartbeats? | Y | N |
| 15. Has anyone in your family died of heart problems or sudden death before the age of 50? | Y | N |
| 16. Do you have or does anyone in your family have Marfan's syndrome? | Y | N |
| 17. Do you have any skin problems (itching, rash, acne)? | Y | N |
| 18. Have you ever had a head injury? | Y | N |
| 19. Have you ever been knocked unconscious? | Y | N |
| 20. Have you ever had a seizure, "fit" or do you have epilepsy? | Y | N |
| 21. Have you ever had a stinger, burner or pinched nerve? | Y | N |
| 22. Have you ever had heat cramps or heat illness? | Y | N |
| 23. Do you have problems exercising in the heat? | Y | N |
| 24. Do you have trouble breathing or do you cough during or after activity? | Y | N |

- | | | |
|--|---|---|
| 25. Do you have a history of asthma? | Y | N |
| 26. Do you have a history of exercise-induced bronchospasm (asthma)? | Y | N |
| 27. Do you use a medically prescribed inhaler or take prescription medication for asthma? | Y | N |
| 28. Do you have diabetes? | Y | N |
| 29. Have you or do you have any other general medical condition (mononucleosis, anemia, etc.) | Y | N |
| 30. Do you use any special equipment (pads, braces, eye guards, etc)? | Y | N |
| 31. Do you have any problems with your eyes or vision? | Y | N |
| 32. Do you wear glasses, contacts or protective eyewear? | Y | N |
| 33. Do you have any problems with your ears or hearing? | Y | N |
| 34. Have you had a previous dental injury? | Y | N |
| 35. Do you wear dental braces? | Y | N |
| 36. Do you have a loose dental appliance (retainer, bridge, etc?) | Y | N |
| 37. Do you wear a mouth guard during athletic participation? | Y | N |
| 38. Are you missing an eye, kidney or testicle? | Y | N |
| 39. When was your last tetanus shot? _____ | | |
| 40. If applicable, when was your first menstrual period? _____ | | |
| 41. If applicable, when was your most recent menstrual period? _____ | | |
| 42. If applicable, what was the greatest length of time between your periods last year? _____ | | |
| 43. Have you ever sprained/strained, dislocated, fractured, or had repeated swelling or other injury any of the following areas: | | |
| ___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Foot | | |
| ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand | | |

Please explain “Yes” answers from the above questions:

Medical information withheld, incomplete, or incorrect may result in incomplete or incorrect medical treatment and may disqualify you from participation on any IWU athletic team.

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of athlete _____ Date _____

Physical Examination

Name: _____ Student ID#: _____

Height: _____ Weight: _____ B/P: _____ / _____ Pulse: _____

Vision: R 20/ _____ L 20/ _____ Corrected?: Y N Pupils: (circle) Equal / Unequal R>L L<R

	Circle (if option given)	Specific Findings
Marfan's syndrome	No Yes	
Heart		
Rhythm	Regular Irregular	
Murmur (supine)	No Yes	
Murmur (standing)	No Yes	
	Normal	
Lungs		
Skin		
Abdominal		
Femoral Pulses		
Genitalia/Hernia		
Musculoskeletal:		
Neck		
Shoulders		
Elbows		
Wrist		
Hands		
Back		
Knees		
Ankles		
Feet		
Romberg's: test for 30 seconds	Right leg: _____ seconds Left leg: _____ seconds	

Medical Clearance

A. Cleared

B. Cleared after completing evaluation/rehabilitation for:

C. Not cleared due to:

Recommendations:

I hereby certify that I examined this athlete and at that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, with the *exception* of:

Men's/Women's Sports: Baseball Softball Basketball Cross Country Soccer Tennis
 Volleyball Track & Field Golf Cheer Team

Signature of Physician: _____ **Date:** _____

Physician (please print): _____ MD DO NP PA (please circle)

Address: _____ State: _____ Zip: _____

Phone: _____

Please return the completed Pre-Participation Physical form to the following address:

Indiana Wesleyan University
ATTN: Head Athletic Trainer
4201 S Washington St
Marion, IN 46953