

## 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 or concussion? How many? _____                         | Y | N |
| 19. Have you ever been knocked unconscious? How many times? _____                          | 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:**

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Medical information withheld, incomplete, or incorrect may result in incomplete or incorrect medical treatment and may disqualify your 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: Right 20 / \_\_\_\_\_ Left 20 / \_\_\_\_\_ Corrected? No Glasses Contacts

Most recent eye exam: \_\_\_\_\_ 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	
	<b>Normal</b>	
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 this time, no physical condition was detected which would prevent this athlete from participating 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