



UNIVERSITY HEALTH SERVICES PRE-PARTICIPATION PHYSICAL EXAMINATION

Name: _____ Date: _____
Sex _____ Age: _____ Date of Birth: _____ Class: _____
List all Varsity Sports: _____ Mobile Phone # _____
_____ Date of Last Exam: _____ email address: _____

The following should be completed by the student athlete with help from the parent(s) only as necessary. The following questions are to be answered yes or no. Please check the appropriate box. Comment on all "yes" answers. (Include dates if possible). For any significant medical or orthopedic problems, please obtain medical records. This may limit delays in your clearance to participate.

Table with 3 columns: YES, NO, COMMENTS. Rows include questions about family history (Diabetes, Sudden Death, High blood pressure, Heart attack, Asthma, Sickle cell anemia, Convulsions, Hypertrophic cardiomyopathy) and personal history (Chest pain, Dizziness, High blood pressure, Racing of the heart, Wheezing, Weakness, Heart murmur, Heart testing, History of kidney).

For the following questions, please provide detailed information (use accessory sheet of paper if necessary), include medical records, and also state the amount of time loss related to each injury/condition.

- | <u>YES</u> | <u>NO</u> | | |
|------------|-----------|--|-------|
| () | () | Been hospitalized for a musculoskeletal problem or had surgery? | _____ |
| () | () | Broken a bone? | _____ |
| () | () | Had a muscle injury? | _____ |
| () | () | Had a knee injury? R () L () Ligament () Meniscus () Other () | |
| () | () | If yes, did you have surgery? Result: | _____ |
| () | () | Had a shoulder injury? R () L () | _____ |
| () | () | If yes, did you have surgery? Result: | _____ |
| () | () | Had a back injury? | _____ |
| () | () | If yes, did you have surgery? Result: | _____ |
| () | () | Had any other joint injuries? Check appropriate box(es): | _____ |
| | | () Hip () Elbow () Wrist () Foot () Other | _____ |
| () | () | Had an MRI, CT scan, bone scan or other special study? If so, please specify when and why | _____ |
| () | () | Had a stress fracture? If yes, state location, method of diagnosis, and time loss | _____ |
| () | () | Do you currently wear prescribed orthotics? If so, why? | _____ |
| () | () | If you have had a musculoskeletal injury, have you recovered fully from this injury and returned to full participation? | |

For any significant medical or orthopedic problems, please obtain medical records.

Have you had or do you now have:

- | | | | |
|-----|-----|---|-------|
| () | () | Hearing loss or perforated eardrum? | _____ |
| () | () | Headaches or migraines? | _____ |
| () | () | Dental plate , impaired vision, wear glasses/contacts? | _____ |
| () | () | Hernia? | _____ |
| () | () | Loss of function or absence of testicle (males),
ovary (females) or other paired organ (eyes, etc) | _____ |

Have you in the past, or do you currently use, or have concerns about:

- | | | | |
|-----|-----|--|-------|
| () | () | Cigarettes, chewing tobacco, or marijuana? | _____ |
| () | () | Recreational drugs or steroids? | _____ |

Do you:

- | | | | |
|-----|-----|---|-------|
| () | () | Feel down, depressed or helpless? | _____ |
| () | () | Have little interest or pleasure in doing things? | _____ |
| () | () | Wear a seat belt 90% of the time? | _____ |
| () | () | Wear a bicycle/motorcycle helmet? | _____ |
| () | () | Understand and regularly perform a self-breast
exam or self-testicular exam? | _____ |
| () | () | Practice safe sex? | _____ |
| () | () | Have a history of > 2 sexual partners in the last 6 months? | _____ |
| () | () | Have a history of any sexually transmitted disease? | _____ |
| () | () | Have any additional concerns or questions? | _____ |

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 avoid certain food groups (carbohydrates, protein, meat, fats, salt, other)? Y N Why? _____

Do you ever feel out of control of your eating patterns? _____

Have you tried to control your weight by: Excessive exercise? Y N, Dieting/Fasting? Y N Vomiting? Y N

Diet pills? Y N Laxatives? Y N Diuretics? Y N

Have you ever had an eating disorder? _____

Have you ever taken supplements to help you gain or lose weight or improve your performance? Y N _____

List any current medications: (include vitamins, over the counter medications, supplements, and birth control pills). _____

List any allergies: (medications, animals, food, pollen) _____

Have you in the past or do you currently use alcohol? Y N _____

Have you in the past or are you currently being treated for an alcohol problem? Y N _____

If you drink alcohol, answer the following questions, selecting the option that comes closest to your answer:

How often do you have an alcoholic drink?	Never	Monthly	2-4 X / mo	2-3 X / wk	4 or > / week
How many alcoholic drinks do you have on a typical day?	0, 1, or 2	3 to 5	6 to 8	10 or more	
How often do you have 4 or more drinks on 1 occasion?	Never	< monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you found you are unable to stop drinking once you've started?	Never	< monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was normally expected of you because of drinking?	Never	< monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you needed a drink in the morning to get yourself going after a heavy night of drinking?	Never	< monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you felt guilty or been remorseful after drinking?	Never	< monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	< monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last year	Yes, in the last year		
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year	Yes, in the last year		

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

(Signature) _____

Date: _____

(Signature of parent if < 18 yrs. Old) _____

Date: _____

PHYSICAL EXAMINATION (To be completed by Princeton University physician)

Blood pressure _____ Pulse _____ Height _____ Weight _____ BMI _____

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		_____
()	()	Neurological		_____

Other: _____

I certify that I have reviewed the history and examined the above athlete, and I recommend sports activity:

Clearance with no limitations: _____

Clearance pending further evaluation or testing: _____

Referral to _____ prior to clearance.

Clearance with limitations : _____

Disqualification from competition: _____

Signature of Examining Physician _____

Date _____