

ITHACA COLLEGE INTERCOLLEGIATE ATHLETICS

Preparticipation Physical Evaluation

The front of this form must be completed, signed and brought with the student to the sports screening.

(Please Print all information on this front side. The back will be completed by IC medical staff during the screening.)

NAME: _____ I.D.Number: _____ AGE: _____ SEX: F M
 EMAIL: _____ Cell phone # _____
 SPORT(S): _____ YEAR IN SCHOOL(CIRCLE ONE): FRESH SOPH JUNIOR SENIOR 5TH
 HAVE YOU EVER HAD A SPORTS CLEARANCE PHYSICAL AT THE ITHACA COLLEGE HEALTH CENTER? If YES, when? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AND HONESTLY AS YOU CAN. If yes give date of injury or illness and details (i.e. right or left, type of injury, illness or operation--What happened?)

Explain "Yes" answers below. Circle questions you don't know the answers to. Y=yes N=no

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|--|---|
| 1 Has a doctor ever denied or restricted your participation in sports for any reason? Y N | 29 Do you have any rashes, pressure sores, or other skin problems? Y N |
| 2 Do you have an ongoing medical condition (like Diabetes or asthma)? Y N | 30 Have you had a herpes skin infection? Y N |
| 3 Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Y N | 31 Have you ever had a head injury or concussion? Y N |
| 4 Do you have allergies to medicines, pollens, foods, or stinging insects? Y N | 32 Have you been hit in the head and been confused or lost your memory? Y N |
| 5 Have you ever passed out or nearly passed out DURING exercise? Y N | 33 Have you ever had a seizure? Y N |
| 6 Have you ever passed out or nearly passed out AFTER exercise? Y N | 34 Do you have headaches with exercise? Y N |
| 7 Have you ever had discomfort, pain, or pressure in your chest during exercise? Y N | 35 Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Y N |
| 8 Does your heart race or skip beats during exercise? Y N | 36 Have you ever been unable to move your arms or legs after being hit or falling? Y N |
| 9 Has a doctor ever told you that you have (check all that apply):
<input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur
<input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection | 37 When exercising in the heat, do you have severe muscle cramps or become ill? Y N |
| 10 Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) Y N | 38 Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Y N |
| 11 Has anyone in your family died for no apparent reason? Y N | 39 Have you had any problems with your eyes or vision? Y N |
| 12 Does anyone in your family have a heart problem? Y N | 40 Do you wear glasses or contact lenses? Y N |
| 13 Has any family member or relative died of heart problems or of sudden death before age 50? Y N | 41 Do you wear protective eyewear, such as goggles or a face shield? Y N |
| 14 Does anyone in your family have Marfan syndrome? Y N | 42 Are you happy with your weight? Y N |
| 15 Have you ever spent the night in a hospital? Y N | 43 Are you trying to gain or lose weight? Y N |
| 16 Have you ever had surgery? Y N | 44 Has anyone recommended you change your weight or eating habits? Y N |
| | 45 Do you limit or carefully control what you eat? Y N |
| | 46 Do you have any concerns that you would like to discuss with a doctor? Y N |

- 17 Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: Y N
- 18 Have you had any broken or fractured bones, or dislocated joints? If yes, circle below: Y N
- 19 Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: Y N

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

- 20 Have you ever had a stress fracture? Y N
- 21 Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Y N
- 22 Do you regularly use a brace or assistive device? Y N
- 23 Has a doctor ever told you that you have asthma or allergies? Y N
- 24 Do you cough, wheeze, or have difficulty breathing during or after exercise? Y N
- 25 Is there anyone in your family who has asthma? Y N
- 26 Have you ever used an inhaler or taken asthma medicine? Y N
- 27 Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Y N
- 28 Have you had infectious mononucleosis (mono) within the last month? Y N

FEMALES ONLY

- 47 Have you ever had a menstrual period? Y N
- 48 How old were you when you had your first menstrual period? _____
- 49 How many periods have you had in the last year? _____

Explain "Yes" answers here: _____

I understand that I must refrain from practice and play whenever restricted from participation by Ithaca College medical or Athletic Training staff. I allow the IC Health Service to share all health information relevant to my athletic participation with IC Athletic Training staff for the duration of my enrollment at Ithaca College, and understand that subsequent disclosure of that information, i.e. to coaches, cannot be controlled by the health center.

DATE _____ Signed _____