

SSU ATHLETIC PRE-PARTICIPATION MEDICAL HISTORY

Athletic Preparticipation Examination For (sport): \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Birthdate / / S.ID# \_\_\_\_\_

Current or Address @ SSU \_\_\_\_\_ Phone ( ) \_\_\_\_\_

# Street or Dorm City State Zip

Permanent Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

# Street City State Zip

**INSTRUCTIONS:** Student athlete must fill out this **Medical History** completely and sign it. It must be reviewed and signed off by the examining physician. **Failure to do so may invalidate athletic insurance coverage and/or interfere with your eligibility to participate in intercollegiate athletics.**

<b>Do you now have or have you ever had any of the following?</b>	Yes	No	Additional Information
Allergy to medications, bee stings, Foods: <b>please list:</b>			
Anemia or bleeding problem?			
Asthma, or severe hayfever?			
Excessive shortness of breath or wheezing with exercise?			
Intense chest pain/pressure with exercise or exertion?			
Dizziness or fainting with exercise or exertion?			
Heart trouble/heart murmur/irregular heartbeat/abnormal EKG?			
High blood pressure/ enlarged heart?			
Heat stroke, heat exhaustion, or other heat related illness?			
Chronic or recurrent illness such as diabetes, epilepsy, sickle cell etc.?			
Other significant illness or exposures ( hepatitis, tuberculosis, etc.)?			
Loss of consciousness, loss of memory, or convulsions?			
Weakness, passing out, or severe headaches?			
Head injury, concussion, or skull fracture?			
Surgery or been advised to have an operation?			
Hospitalization(s)? <b>List reason:</b>			
Bone, joint, or muscle injuries or problems (includes dislocations, separations, sprains, broken bones, etc)?			
Neck injury, back injury, or back problems or surgery?			
Hip, knee, ankle, shoulder, wrist, elbow, problems or surgery?			
Hernia or kidney problem?			
Eye, ear, or significant dental problems or injuries?			
Menstrual irregularities? <b>List date of last period:</b>			
Skin problems, including recurrent rashes, infection, etc.?			
Any other important illness, injury, or medical condition?			
<b>Do you:</b> Wear glasses, contact lenses, dental bridges, etc.?			
Have full function of and presence of all paired organs, (i.e., eye, kidney, testicle, ovary, lung)?			
Take medication on a regular basis? <b>Please list:</b>			
<b>Has any blood relative:</b>			
Died suddenly or had a heart attack at less than age 50?			
Been diagnosed with Marfan syndrome?			
Has your athletic playing status ever been interrupted or limited because of illness or injury?			
Do you know of any medical reason that might limit your participation in sports?			
<b>Immunization Verification:</b>			<b>NOTE: attach copies of documentation of required immunizations.</b>
Date of last <b>Tetanus</b> _____ (verified by physician)			
Date of most recent <b>Measles/Rubella</b> _____			
Date of <b>Hepatitis B</b> series (required if under 19) 1 / 2 / 3 _____			

I certify that the above information is correct, and authorize the transfer of medical information to the SSU Athletic Trainer, team physician, and SSU Student Health Center:

\*Athlete's signature: \_\_\_\_\_

Date: / /

\*Reviewed by physician \_\_\_\_\_  
 Signature and license number

Date: / /

Name \_\_\_\_\_ Sex: M F Date: \_\_\_\_\_

**The following is for medical use only:**

Vitals: Ht (in.): _____ Wt (lb.): _____ Pulse (resting): _____ Pulse (post exercise): _____ B/P sitting: _____ / _____ Cuff size: Med _____: Large _____:			Comments/Recommendations
Visual Acuity: Uncorrected: R 20/ _____ L 20/ _____ Corrected: R 20/ _____ L 20/ _____ (with glasses/contacts)			
<b>A. GENERAL MEDICAL EXAM</b>	O.K. 4	Description/Problem	Comments/Recommendations
General			
Head and Neck			
Eyes Pupils/EOM's Other			
ENT			
Oral/Dental			
Skin			
Lymphatics			
Cardiovascular Rhythm/Murmurs			
Chest/Lungs			
Abdomen			
Hernia/Genitalia			
General Neuro			
Other			

Medically cleared: \_\_\_ yes \_\_\_ no or temporarily cleared until: \_\_\_\_\_

Partial clearance: \_\_\_ yes activities limited to: \_\_\_\_\_

Needs the following prior to complete clearance: \_\_\_\_\_

**\*M.D. Signature for Part A**

license #

Date

<b>B. NEURO MUSCULAR &amp; ORTHOPEDIC EXAM</b>	O.K. 4	Description/Problem	Comments/Recommendations
Neurological - peripheral			
Spine: Cervical			
Shoulders			
Arms/Elbows/Wrists/Hands			
Hips/Knees			
Ankles/Feet			
Flexibility			
Other			

1. Clearance OK after ATC evaluation for: \_\_\_\_\_

2. Needs clearance referral to Team Physicians for: \_\_\_\_\_

3. Orthopedically Cleared: \_\_\_\_\_ Yes \_\_\_\_\_ NO

M.D. Signature for Part B

license #

Date