

Bowling Green State University
Pre-Participation Physical Evaluation- New Athletes

History

Date of Exam _____

Name _____	Sex ____	Age ____	Date of Birth _____
SS# _____	Sports _____		
Address _____		Phone _____	

Explain "Yes" answers below.

Circle questions you don't know the answers to.

		Yes	No		Yes	No	
1.	Have you had a medical illness or injury since your last check up or sport physical?	<input type="checkbox"/>	<input type="checkbox"/>	10.	Do you use an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have an ongoing or chronic illness? (i.e. diabetes, high blood pressure, hepatitis, kidney disease.)	<input type="checkbox"/>	<input type="checkbox"/>		Do you have a complete and functional set of paired organs (i.e., eyes, ears, kidneys, testicles)?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	11.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>		Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	12.	Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever taken or are you currently taking any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>		Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have any allergies (for example, to medicine, pollen, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>		Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		If yes, check the appropriate box and explain below.		
5.	Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
	Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
	Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
	Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
	Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
	Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
	Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	14.	Have you had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you had a severe viral infection (for example, mononucleosis, or myocarditis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	15.	Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
	Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>		Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
	Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	16.	Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
	Is there a family history of heart problems in a close relative younger than age 50 (i.e. enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)?	<input type="checkbox"/>	<input type="checkbox"/>		Do you think you are in good health?	<input type="checkbox"/>	<input type="checkbox"/>
	Is there a family history of chronic illness (i.e., high blood pressure, diabetes, hepatitis, sickle cell anemia, kidney disease, or Marfan's syndrome)?	<input type="checkbox"/>	<input type="checkbox"/>		Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>		Do you use street drugs?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	17.	Record the dates of your most recent immunizations		
	Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>		Tetanus _____	Measles _____	
	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B _____	Chickenpox _____	
	Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY			
	Have you ever had a numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	18.	When was your first menstrual period? _____		
	Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>		When was your most recent menstrual period? _____		
8.	Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>		How much time do you usually have from the start of one period to the start of another? _____		
	Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>		How many periods have you had in the last year? _____		
9.	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>		What was the longest time between periods in the last year? _____		
	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here: _____			

I hereby state that, to the best of my knowledge, my answers to the above question are complete and correct. I give permission for the Athletic Department and Student Health Service to share this information.

Signature of athlete _____ Date _____

I have reviewed this history with the student-athlete, documented all yes answers, and requested all necessary medical records.

Signature of Staff ATC _____ Date _____