# Texas College Athletics Pre-participation Physical Examination

**Athletes complete *BEFORE* Doctor's physical exam.**

**HISTORY:** Date of Examination: _____

Name: _____ Male / Female Age _____ Date of Birth: _____

Sport (s)_____ Year in School _____

Address _____

Phone _____ SSN _____

***In case of Emergency, contact:***

Name _____ Relationship _____ Phone (H)_____

(W) _____ (C) _____

Name _____ Relationship _____ Phone (H)_____

(W) _____ (C) _____

**Circle questions you don't know the answer to. Explain "YES" answers below.**

| | | | |
|---|---|---|---|
| Have you had a medical illness or injury since your last checkup or sports physical? | Y N | Have you had any problems with your eyes or vision? | Y N |
| Have you ever been hospitalized overnight? | Y N | Have you ever had a sprain, strain, or selling after an injury? | Y N |
| Have you ever had surgery? | Y N | Have you broken or fractured any bones or dislocated any joints? | Y N |
| Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | Y N | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | Y N |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | Y N | Do you want to weigh more or less than you do now? | Y N |
| Do you have any allergies (for example: to pollen, medicine, food or stinging insects)? | Y N | Do you have sickle cell trait or disease? | Y N |
| Have you ever had a rash or hives develop during or after exercise? | Y N | **FEMALES ONLY:** | |
| Have you ever passed out during or after exercise? | Y N | When was your first menstrual period? | |
| Have you ever been dizzy during or after exercise? | Y N | When was you most recent menstrual period? | |
| Have you ever had chest pain during or after exercise? | Y N | How much time do you usually have from the start of one period to the start of another? | |
| Do you get tired more quickly than your friends do during exercise? | Y N | How many periods have you had in the past year? | |
| Have you ever had racing of your heart or skipped heartbeats? | Y N | What was the longest time between periods last year? | |
| Have you had high blood pressure or high cholesterol? | Y N | **EXPLAIN "YES" ANSWERS HERE:** | |
| Have you ever been told you have a heart murmur? | Y N | | |
| Has any family member or relative died of heart problems or of sudden death before age 50? | Y N | | |
| Have you had a severe viral infection (i.e. myocarditis or mononucleosis) with the past month? | Y N | | |
| Has a physician ever denied or restricted your participation in sports for any heart problem? | Y N | | |
| Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, or blisters)? | Y N | | |
| Have you ever had a head injury or concussion? | Y N | **I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.** | |
| Have you ever been knocked out, become unconscious, or lost your memory? | Y N | | |
| Have you ever had a seizure? | Y N | **Signature of Athlete** | |
| Do you have frequent or severe headaches? | Y N | _____ | |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | Y N | **Date _____** | |
| Have you ever had a stinger, burner, or pinched nerve? | Y N | | |
| Have you ever become ill from exercising in the heat? | Y N | | |
| Do you cough, wheeze, or have trouble breathing during or after activity? | Y N | | |
| Do you have asthma? | Y N | | |
| Do you have seasonal allergies that require medical treatment? | Y N | | |
| Do you use any special protective or corrective equipment devices that aren't usually used for your sport or position (for example: knee brace, foot orthotics, retainer on your teeth, or hearing aid)? | Y N | | |

# Texas College Athletics Pre-participation Physical Examination

PHYSICAL EXAMINATION (PHYSICIAN COMPLETES AFTER REVIEW OF ATHLETE'S HISTORY):

**Name: _____ Date of Birth _____**

**Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____**

| MEDICAL | Normal | Abnormal Findings: |
|---|---|---|
| Appearance | | |
| Eyes/ears/nose/throat | | |
| Lymph Nodes | | |
| Heart | | |
| Lungs | | |
| Abdomen | | |
| Genitalia (males only) | | |
| Skin | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/Hand | | |
| Hip/Thigh | | |
| Knee | | |
| Leg/Ankle | | |
| Foot | | |

## CLEARANCE

☐ Cleared ☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

_____

☐ Not Cleared for: _____ Reason: _____

_____

_____

_____

NAME OF PHYSICIAN (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of Physician: _____