Mercer County Community College Athletic Training

PREPARTICIPATION PHYSICAL EVALUATION

Complete all information below.

Health History forms and must be completed by the student-athlete prior to their scheduled physical appointment

Name: _____Sport: _____ (Mens/Womens)

Preferred Name:_____ Date of Birth: _____ Gender: _____

Home Phone:_____Cell Phone:_____Email:_____

Year of Participation: _____ First _____ Second _____ Transfer

Are you an International Student? _____YES _____ NO

Permanent Address

_____

STREET TOWN STATE ZIP CODE

_____

Country

Address when attending Mercer (if different from permanent address)

Home Address: _____

STREET TOWN STATE ZIP CODE

Emergency Contact Information

Name:_____Phone:_____Relationship:_____

Email: _____

Name:_____Phone:_____Relationship:_____

Health Insurance Information: Do you have personal health insurance coverage? ☐ YES ☐ No

Insurance Company Name:_____ Policy # _____

Group #_____ Address _____

Policy Holder Name:_____ DOB:_____ Relationship:_____

Please submit photocopy of health insurance card, both front and back.

Academic Information:

Do you have an Individualized Educational Plan (IEP) implemented during elementary and/or high school? YES / NO

If yes, have you submitted you IEP to the Office of Special Academic Services at Mercer CCC? YES / NO

Complete all of the following information. If answer yes, provide dates and give relative explanation.

Please list all prescription medications, over-the-counter medicines and supplements you are currently taking:			
Do you have any Allergies? ____ Yes ____ No ***If yes, what are you allergic to?***			
Please indicate if you have ever had any of the following:	**YES**	**NO**	**If yes, please explain and provide dates of occurrence:**
Atlantoaxial instability			
X-ray evaluation for atlantoaxial instability			
Dislocated joints			
Easy bleeding			
Enlarged spleen			
Osteopenia or osteoporosis			
Difficulty controlling bowel			
Difficulty controlling bladder			
Numbness or tingling in arms or hands			
Numbness or tingling in legs or feet			
Weakness in arms or legs			
Weakness in legs or feet			
Recent change in coordination			
Recent change in ability to walk			
Spina bifida			
Latex allergy			
Diagnosed and treated for any type of cancer or malignancy			
Drug or alcohol treatment			
FEMALES ONLY	**YES**	**NO**	
Do you have a normal menstrual cycle (every 28 days)?			

MEDICAL HISTORY: Please answer completely. If you answer yes to any questions, please explain in the space provided below.

GENERAL QUESTIONS	YES	NO	If yes, please explain and provide necessary dates.
1. Has a doctor ever denied or restricted your participation in sports for any reason?			
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Diabetes ☐ Infections ☐ Sickle Cell Disease or SCT ☐ Tuberculosis Other:_____			
3. Have you ever spent the night in the hospital?			
4. Have you ever had surgery?			
MEDICAL QUESTIONS	**YES**	**NO**	
5. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
6. Have you ever used an inhaler or taken asthma medicine?			
7. Is there anyone in your family who has asthma?			
8. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
9. Do you have a groin pain or a painful bulge or hernia in the groin area?			
10. Have you had infectious mononucleosis (MONO) within the last month?			
11. Have you ever had a head injury or concussion?			
12. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
13. Do you have any rashes, pressure sores, or other skin problems?			
14. Have you ever had herpes or MRSA skin infection?			
15. Do you have a history of seizure disorder?			
16. Do you have headaches with exercise?			
17. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
18. Have you ever been unable to move your arms or legs after being hit or falling down?			
19. Have you ever become ill while exercising in the heat?			
20. Do you get frequent muscle cramps when exercising?			
21. Do you get frequent muscle cramps when exercising?			
22. Have you had any problems with your eyes or vision?			
23. Have you had any eye injuries?			
24. Do you wear glasses or contact lenses?			
25. Do you wear protective eyewear, such as goggles or face shield?			
26. Do you worry about your weight? Are you trying to or has anyone recommended that you gain or lose weight?			
27. Are you on a special diet or do you avoid certain types of foods?			
28. Have you ever been diagnosed with an eating disorder?			
29. Have you ever or are you currently being treated y a physician for mental health?			

MENTAL HEALTH QUESTIONS	YES	NO		YES	NO
I often have trouble sleeping.			I struggle with being confident.		
I wish I had more energy most days of the week.			I don't feel hopeful about the future.		
I think about things over and over.			I have a hard time managing my emotions (frustration, anger, impatience).		
I feel anxious and nervous much of the time.			I have feelings of hurting myself or others.		
I often feel sad or depressed.					

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature: _____ Date: _____

Medical History Continued: Please answer completely. If you answer yes to any questions, please explain in the space provided below

HEART HEALTH QUESTIONS ABOUT YOU	YES	NO	If yes, please explain and provide necessary dates.
30. Have you ever passed out or nearly passed out DURING or AFTER exercise?			
31. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
32. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ Heart Murmur ☐ Heart Infection ☐ High cholesterol ☐ Kawasaki Disease Other:_____			
33. Has a doctor ever ordered a test for your heart (ECG/EKG, echocardiogram)?			
34. Do you get lightheaded or feel more short of breath than expected during exercise?			
35. Have you ever had an unexplained seizure?			
36. Do you get more tired or short of breath more quickly than your friends during exercise?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**	**If yes, please explain and provide necessary dates.**
37. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?			
38. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, arrhymogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?			
39. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			
40. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			
BONE AND JOINT QUESTIONS	**YES**	**NO**	**If yes, please explain and provide necessary dates.**
41. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?			
42. Have you ever had any broken or fractured bones or dislocated joints?			
43. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			
44. Have you ever had a stress fracture?			
45. Have you ever been told that you have or have you has an x-ray for neck instability or atlantoaxial instability (Down Syndrome or dwarfism)?			
46. Do you regularly use a brace, orthotics or other assistive device?			
47. Do you have a bone, muscle, or joint injury that bothers you?			
48. Do any of your joints become painful, swollen, feel warm, or look red?			
49. Do you have any history of juvenile arthritis or connective tissue disease?			

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature: _____ Date: _____

Mercer County Community College Athletic Training ***To be completed and signed by Physician***
PREPARTICIPATION PHYSICAL EVALUATION

Name: _____ Date of Birth:_____ Sport:_____

Examination		
Height **Weight** **Gender:**		
BP **Pulse** **Vision R 20/** **L 20/** **Corrected □ Y □ N**		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine +/- Valsalva • Location of point of maximal impulse (PMI)		
Pulses (simultaneous femoral and radial pulses)		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggested of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional • Duck walk, single leg hop		

_____ Cleared for all sports without restriction
_____ Cleared for all sports without restriction with recommendations for further evaluation or treatment for:

_____

_____ Not Cleared for athletic participation
Reason: _____
Recommendations: _____

_____

I have examined the above named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete is cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete.

Physician Signature _____ Date of Exam_____

Print Name (physician, APN, PA)_____ Phone _____

Address _____

****Provide Medical License Number and Practice Stamp**

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