

**RIDER UNIVERSITY ATHLETICS PRE-PARTICIPATION PHYSICAL EVALUATION 2007-2008**

Full Name \_\_\_\_\_ Age \_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex M / F  
 S.S.N \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sport(s) \_\_\_\_\_ Year Fr. So. Jr. Sr. 5th

**Medical History: Explain "YES" answers in the space provided below.**

- |  | YES                      | NO                       |   | YES                      | NO                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sport?                                 | <input type="checkbox"/> | <input type="checkbox"/> | 30. When exercising in the heat, do you have severe muscle cramps or become ill?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes)?   | <input type="checkbox"/> | <input type="checkbox"/> | 31. Has a doctor told you that you or someone in your family has sickle cell disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription medications, pills?                    | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you had any problems with your eyes or vision?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out or nearly passed out DURING exercise?                                      | <input type="checkbox"/> | <input type="checkbox"/> | 33. Do you wear glasses or have contacts?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out AFTER exercise?                                       | <input type="checkbox"/> | <input type="checkbox"/> | 34. Do you wear protective eyewear?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had pain, discomfort, or pressure in your chest during exercise?                      | <input type="checkbox"/> | <input type="checkbox"/> | 35. Do you regularly use a brace or assistive device?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has a doctor ever told you you have (check all that apply)  |                          |                          | 36. Are you happy with your weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> high blood pressure <input type="checkbox"/> a heart murmur                   |                          |                          | 37. Do you want to lose or gain weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> high cholesterol <input type="checkbox"/> a heart infection                   |                          |                          | 38. Has anyone recommended you change your weight or eating habits?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 39. Do you limit or control what you eat?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever ordered a test for your heart (like an EKG or echocardiogram)?                    | <input type="checkbox"/> | <input type="checkbox"/> | 40. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:         | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has anyone in your family died for no apparent reason?   | <input type="checkbox"/> | <input type="checkbox"/> | 41. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Does anyone in your family have a heart problem?   | <input type="checkbox"/> | <input type="checkbox"/> | 42. Have you had a bone or joint injury that requires x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has any family member or relative died of heart problems or sudden death before 50?                | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 13. Does anyone in your family have Marfan syndrome?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 14. Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 15. Do you cough, wheeze, have asthma, or have trouble breathing during or after exercise?             | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 16. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 17. Has a doctor ever told you that you have asthmas or allergies?                                     | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 18. Have you ever used an inhaler or taken asthma medication?  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 19. Were you born without or are you missing any organs?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 20. Have you had an infectious mononucleosis (mono) within the last month?                             | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 21. Do you have any rashes, pressure sores, or other skin problems?                                    | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 22. Have you ever had a herpes skin infection?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 23. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 24. Have you been hit in the head or been confused or lost your memory?                                | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 25. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 26. Do you have headaches when you exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 27. Have you been told that you have or have you had an x-ray for neck instability?                    | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 28. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 29. Have you ever been unable to move your arms or legs after being hit or falling?                    | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
|  |                          |                          |   |                          |                          |

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Low Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

**FEMALES ONLY**

43. Have you had a stress fracture?
44. Do you have any concerns that you would like to discuss with the doctor?
45. Have you ever spent the night in a hospital?
46. How old were you when you had your first menstrual period? \_\_\_\_\_
47. How many periods have you had in the last 12 months? \_\_\_\_\_
48. When was your last menstrual period? \_\_\_\_\_

**Explain "YES" answers here:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

I give permission for the pre-participation screening to be provided by the Rider University athletics department. I give permission for the University and its agents to administer first aid and/ or medical care at the time of any injury, including actual game competition. I understand that failure to disclose any medical information may invalidate my insurance coverage, and under NCAA rules, may cancel my eligibility. I have read and I understand the above. I/ We authorize the Rider University Sports Medicine Department to share information necessary for treatment with Rider team physicians, student health services, coaches, administrators, and parent(s)/ guardian(s). I have been informed that I have the right to revoke this authorization at any time. I understand that my medical records are kept secure and that I have the right to view those records upon request.

Signature of athlete \_\_\_\_\_

Signature of parent/ guardian (if under 18 years of age) \_\_\_\_\_

Date \_\_\_\_\_

Pre-participation Physical Evaluation:

Athlete Name \_\_\_\_\_ S.S.N. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ Vision L 20/ \_\_\_\_\_ R 20/ \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	EXAMINER
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Gross hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomn			
Genitourinary (males)			
skin			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	EXAMINER
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

**Clearance**

**Cleared**

**Cleared after further evaluation/ rehabilitation for:** \_\_\_\_\_

\_\_\_\_\_

**Not Cleared** due to: \_\_\_\_\_

\_\_\_\_\_

**Recommendations:** \_\_\_\_\_

\_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_