ATHLETICS PRE-PARTICIPATION EVALUATION FORM
HISTORY FORM

1. All students participating in intercollegiate athletics must complete this form and physical examination within the 6 MONTHS PRIOR to the first collegiate practice.
2. This form is to be filled out by the patient prior to seeing the healthcare provider.
3. **It is the student's responsibility to upload this form via *HEALTHY ROSTER*. You will receive an email from them with instructions on how to do this.**

Saint Mary's University OF MINNESOTA

ATHLETIC TRAINING
700 TERRACE HEIGHTS #62
WINONA, MN 55987-1399 USA
PHONE 507-457-1759
FAX 507-494-6093

Date of Exam: _____

Name: _____

Date of birth: _____ Gender: _____ Age: _____

Sport(s): _____

MEDICINES AND ALLERGIES: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

_____

_____

Do you have any allergies? ☐ Yes ☐ No
If yes, please identify specific allergy: ☐ Medicine ☐ Pollens ☐ Food ☐ Stinging Insects
Explain "Yes" answers:

_____

CHRONIC CONDITIONS:

_____

_____

GENERAL QUESTIONS	Yes	No
1. Has a healthcare provider ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Have you ever been told that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other:		
9. Have you ever had a test for your heart? (i.e. ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. 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)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		

BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	**Yes**	**No**
26. Do you cough, wheeze or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a healthcare provider?		
FEMALES ONLY		
52. How old were you when you had your first menstrual period?		
53. How many periods have you had in the last 12 months?		

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 understand that professional staff in Student Health Services and Athletic Training may exchange information regarding my health.

Signature of athlete _____ Date _____

If under 18 years of age,
signature of parent/guardian _____ Date _____

ATHLETICS PRE-PARTICIPATION EVALUATION FORM
PHYSICAL EXAMINATION FORM

Saint Mary's University OF MINNESOTA

NAME: _____

DATE OF BIRTH: _____

PHYSICIAN REMINDERS:

1. Consider additional questions on more sensitive issues:
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION

Height Weight ☐ Male ☐ Female BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected ☐ Y ☐ N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance[a]		
Eyes/ears/nose/throat		
Lymph nodes		
Heart[b]		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)[c]		
Skin		
Neurologic[d]		
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		

[a] Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)
[b] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[c] Consider GU exam if in private setting. Having third party present is recommended.
[d] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

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

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

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. A copy of the physical exam is on record in my office and can be made available to the school at the request of the student. If conditions arise after the athlete has been cleared for participation, the healthcare provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete.

Name of healthcare provider (print/type) _____ Date _____

Address _____ Phone _____

Signature of healthcare provider _____ DO/MD/NP/PA