

**TWC Annual Pre-Participation Physical Evaluation
2010-2011**

Returning Athletes: answers based on last 12 months

Freshman/Transfer Athletes: answers based on last 5 years

Name: _____ Sex: _____ DOB: ___/___/___ SS#: ___/___/___ Age: _____
Sport(s): _____ Year (circle one): **Fresh** **Soph** **Jr** **Sr**

Has your insurance changed since last year (circle one)? **yes** **no**

Explain all "Yes" answers at the bottom of this sheet

- | | | |
|---|-----|----|
| 1. Have you been hospitalized?..... | yes | no |
| Have you had surgery?..... | yes | no |
| 2. Are you presently taking any medication or pills?..... | yes | no |
| 3. Have you developed any new allergies (medications, insects, bees)?..... | yes | no |
| 4. Have you passed out during or after exercise?..... | yes | no |
| Have you been dizzy during or after exercise?..... | yes | no |
| Have you had chest pain during or after exercise?..... | yes | no |
| Do you tire more quickly than your friends during exercise?..... | yes | no |
| 5. Have you had a high blood pressure reading this year?..... | yes | no |
| Have you been told in the past 12 months that you have a heart murmur?..... | yes | no |
| Have you had racing of your heart or skipped heartbeats?..... | yes | no |
| Has anyone in your family died of heart problems or sudden death before age 50?..... | yes | no |
| 6. Do you have any skin problems? (itching, rashes, acne, etc.)..... | yes | no |
| 7. Have you had a head injury?..... | yes | no |
| Have you been knocked out or unconscious? | yes | no |
| Have you had a seizure?..... | yes | no |
| Have you had a stinger, burner, or pinched nerve? | yes | no |
| 8. Have had heat illness or muscle cramps?..... | yes | no |
| Have you been dizzy or passed out from the heat?..... | yes | no |
| 9. Do you have trouble breathing or do you cough during or after any activity? | yes | no |
| 10. Do you use any special equipment (pads, braces, mouth guards, etc.)? | yes | no |
| 11. Have you had any problems with your eyes or vision?..... | yes | no |
| Do you wear contacts, glasses, or protective eyewear?..... | yes | no |
| 12. Have you sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of ANY bones or joints?..... | yes | no |

Circle all that apply:

| | | | | | | |
|------|-----------|-------|-------|-------|------|-------|
| Head | Shoulder | Thigh | Neck | Elbow | Knee | Chest |
| Back | Shin/Calf | Wrist | Ankle | Hip | Hand | Foot |

- | | | |
|---|------------|-----------|
| 13. Have you had any medical illnesses (mono, diabetes, etc.) in the past 12 months?..... | yes | no |
| 14. Have you gained or lost more than 10 pounds in the last 12 months?..... | yes | no |
| 15. Do you have any medical concerns that you would like to speak to a Doctor about?..... | yes | no |
| 16. Have you had a medical problem/injury since your last evaluation by a physician? | yes | no |

Female Athletes complete the following:

- | | | |
|---|-----|----|
| 17. When was your first menstrual period (approx. age)? _____ | | |
| 18. When was your last menstrual period (approx. date)? _____ | | |
| 19. Have you skipped any period in the last 12 months? | yes | no |
| 20. If yes, what was the longest time between your periods last year? _____ | | |
| 21. Are you pregnant? | yes | no |

Explain all "Yes" answers:

I herby state to the best of my knowledge, my answers to the above questions is correct.

Student Athlete Signature: _____ **Date:** _____

History continued on the back

STUDENT-ATHLETE: DO NOT WRITE BELOW THIS LINE

Vital Statistics Information

| Date | Height/ Weight | Blood Pressure | Pulse | Vision Correction (yes/no) |
|------|----------------|----------------|-------|----------------------------|
| | | | | |

| | Normal | Abnormal Findings | MD Initials |
|-------------------|--------|-------------------|-------------|
| MEDICAL | | | |
| Cardiopulmonary | | | |
| Pulses | | | |
| Heart | | | |
| Lungs | | | |
| Skin | | | |
| Abdominal | | | |
| ORTHOPEDIC | | | |
| Neck | | | |
| Shoulder | | | |
| Elbow | | | |
| Wrist | | | |
| Hand | | | |
| Back | | | |
| Knee | | | |
| Ankle | | | |
| Foot | | | |
| Other | | | |

Medical Clearance (Circle One): **CLEARED** **LIMITED CLEARANCE** **NOT CLEARED**

Explain: _____

Name of Physician (Print): _____

Physician Signature: _____ Date: _____

Orthopedic Clearance (Circle One): **CLEARED** **LIMITED CLEARANCE** **NOT CLEARED**

Explain: _____

Name of Physician (Print): _____

Physician Signature: _____ Date: _____

Recommendations:

| Reviewing ATC | Date | Rec'd Current Insurance Info | File Updated in SportsWare |
|---------------|------|------------------------------|----------------------------|
| | | | |