

**TWC Annual Pre-Participation Physical Evaluation
2011-2012**

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