



Union County College

Athletic Department

Preparticipation Physical Evaluation

Date _____ Sport _____

Name _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Personal Physician (Name & Contact info) _____

In case of emergency, contact:

Name _____ Relationship _____ Phone _____ Work _____

Explain (Yes) answers below.

Circle the questions that you don't know the answer to. Y N Y N

- 1. Have you had a medical illness or injury since your last check up or sports physical? Do you have an ongoing or chronic illness?
2. Have you ever been hospitalized overnight? Have you ever had surgery?
3. Are you currently taking any prescriptions or nonprescription (over-the-counter) medications, pills or an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
4. Do you have any allergies (for example; pollen, medicine, food or stinging insects)? Have you ever had a rash or hives develop during or after exercise?
5. Have you ever passed out or been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends during or after exercise? Have you ever had racing of your heart or skipped heartbeats? Have you ever had high blood pressure or high cholesterol? Have you ever been told that you have a heart murmur? Has any of your family members died of heart problems or of sudden death before the age of 50? Have you ever had sever viral infection(for example; myocardrtus, or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?
6. Do you have any current skin problems(for example, itching, rashes, acne, warts, fungus, or blisters)?
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious? or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches?
8. Have you ever had numbness or tingling in your arms, hands, legs, feet?
9. Have you ever become ill from exercising in the heat?
10. Do you cough, wheeze or have trouble breathing during or after activity? Do you have asthma or seasonal allergies that require medical treatment?
11. Do you use any special protective or corrective equipment or devices that aren't used for your sport(for example; knee brace, retainer on your teeth, hearing aid)?
12. Have you had any problems with your eyes or vision? Do you wear contacts or glasses?
13. Have you ever had a sprain, strain, or swelling after injury? Have you ever broken or fractured any bones or dislocated any joints? If yes, check appropriate line and explain below. Head Elbow Hip Neck Forearm Thigh Back Wrist Knee Chest Hand Shin/Calf Shoulder Finger Ankle Upper Arm Foot
FEMALES ONLY
14. When was your first menstrual period? When was your most recent menstrual period? How many days between periods? Explain "Yes" answers here:



Student 's Name _____

Union County College

Team Physician's Report

Height _____

Blood Pressure _____

Weight _____

Pulse _____

Ears, Nose, Throat _____

Neck _____

Cardiac _____

Pulmonary _____

Abdomen _____

Musculoskeletal _____

Neurological _____

Passed _____

Failed _____

Physician's Comments _____

Physician's Signature Date