



Name: _____

School Year: _____

Classification: *(Please Circle)* FRESHMAN SOPHOMORE JUNIOR SENIOR 5TH YEAR SENIOR

Sport: *(Please Circle)*

BASEBALL

M-BASKETBALL

W-BASKETBALL

EQUESTRIAN

FOOTBALL

M-GOLF

W-GOLF

RIFLE

SOCCER

M-SWIM/DIVE

W-SWIM/DIVE

M-TENNIS

W-TENNIS

M-TRACK/CC

W-TRACK/CC

VOLLEYBALL

ALLERGIES: _____

Physician Use Only Below This Line

- Cleared without restrictions
- Cleared, with recommendations for further evaluation or treatment for:

- Not Cleared Reason: _____

Recommendations:

Physician Name: _____

(circle one) MD DO

Physician Signature: _____

TCU Sports Medicine Preparticipation Physical Exam

History Form

Name: _____ Sex: _____ Age: _____ Date of Birth: _____
month / day / year

**Explain 'Yes' answers in the space provided.
 Circle questions you don't know the answer to.**

	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur		
<input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, EKG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>

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

20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you had a severe viral infection (like mononucleosis or myocarditis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
39. Have you ever had a skin infection (Staph) requiring antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>
40. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
41. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
42. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
43. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
44. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
45. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
46. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
47. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

FEMALES ONLY

48. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
49. How old were you when you had your first menstrual period?	_____	
50. How many periods have you had in the past 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.

Athlete Signature: _____

Date: _____

Name: _____

Examination Form

Height: _____ Weight: _____ Pulse: _____ BP: / (/ , /)

Vision: R 20/____ L 20/____ Corrected: Yes No Pupils: *Equal Unequal*

	NORMAL	ABNORMAL FINDINGS/RECOMMENDATIONS	INITIALS
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary			
Skin			

	NORMAL	ABNORMAL FINDINGS/RECOMMENDATIONS	INITIALS
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			