WNE CENTER FOR Health & Well-Being

Physical Examination

1. The physical examination date can be no earlier than 1 year prior to the first day of classes and for athletes no earlier than 6 months prior (NCAA)
2. Completed forms should be uploaded to the health portal (https://wne.medicatconnect.com/home.aspx)

Name_____Date ofBirth:_____

Height_____Weight_____BP_____Pulse_____Vision R 20/_____L 20/_____Corrected Yes/No

	Normal	Abnormal Findings
Appearance (Marfan stigmata)		
Skin		
Eyes, Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal/Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neurological, Psychiatric		
Functional mobility		

Is there any reason this student should not participate in sports or rigorous activities? Yes No Specify

Is the patient now under treatment for emotional or psychological conditions? Yes No Specify

Do you have any recommendations regarding the care of this student? Yes No Specify

Print or Stamp

Provider'sName_____Address_____Phone_____

Signature _____MD/DO/NP DateofExam _____

Athletic Preparticipation Evaluation

This form MUST be completed by intercollegiate athletes and cannot be done prior to 6 months before the start of the semester. This form must be reviewed and signed by your primary care provider. Further documentation may be requested by health services, athletic training, or the team physician.

Name _____Sex _____ Age _____ Date Birth_____Sport/Sports_____

	YES	NO
Have you had a medical illness or injury		
Do you have an ongoing or chronic illness?		
Have you ever been hospitalized overnight?		
Have you ever had surgery?		
Are you currently taking any prescription or over-the-counter medication or using an inhaler?		
Have you ever taken any supplements/vitamins to help you gain or lose weight or improve your performance?		
Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
Have you ever passed out during or after exercise? *		
Have you ever been dizzy during or after exercise? *		
Have you ever had chest pain, pressure, or chest tightness during or after exercise? *		
Do you get tired more quickly than your friends during 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 you have a heart murmur? *		
Has any family member or relative died of heart problems or of sudden death before age 50? *		
Have you or your family ever been diagnosed with a genetic heart problem or pacemaker? *		
Have you had a severe viral infection like myocarditis or mononucleosis within the last month? *		
Has a health care provider ever denied or restricted your participation in sports for any heart problems? *		
Has a health care provider ever requested a test for your heart? (EKG/ECHO) *		
Do you have any current skin problems (ex: itching, rashes, acne, warts, fungus, or blisters)?		
Have you ever had a head injury or concussion?		
Have you ever been knocked out, become unconscious, or lost your memory?		
Do you have frequent, prolonged, or severe headaches?		
Have you ever had numbness or tingling in your arms, legs, or feet?		

	YES	NO
Have you ever had a burner, stinger, or pinched nerve?		
Have you ever had a seizure?		
Have you ever become ill from exercising in the heat?		
Do you cough, wheeze or have trouble breathing?		
Do you have asthma?		
Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
Do you or does someone in your family have sickle cell trait or disease?		
Do you use any special protective or corrective equipment that for your sport or position (ex: knee brace, special neck roll, foot orthotics, retainer or hearing aid)?		
Have you had any problems with your eyes or vision?		
Have you ever had a sprain, strain or swelling after an injury?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? (If yes check appropriate box and explain below) ❑Head ❑Elbow ❑Hip ❑Neck ❑Forearm ❑Thigh ❑Back ❑Hand ❑Wrist ❑Knee ❑Chest ❑Finger ❑Ankle ❑Foot ❑Shin or calf ❑Upper Arm ❑Shoulder		
Do you want to weigh more or less than you do now?		
Do you regularly lose weight to meet weight requirements for your sport?		
Have you ever had an eating disorder?		
Do you feel stressed or under a lot of pressure?		
Do you ever feel sad, hopeless, depressed, or anxious?		
Have you had COVID 19?		
Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
Menstrual Questions Only		
When was your first menstrual period? When was your most recent menstrual period? How many periods have you had in the last year?		

Explain all "YES" answers here

I hereby state that, to the best of my knowledge, my answers to the questions are complete and correct.

Signature of Athlete (parent/guardian if under 18) _____Date: _____

The remainder of this form is to be completed and *signed* by the licensed health care provider:

After reviewing this health history form with the patient/athlete I have determined that they are

Cleared ❑ Cleared with Recommendations (reason and comments on reverse) ❑ Not cleared ❑

*ECG and referral to cardiologist for any abnormal cardiac history or examination findings or a combination of both.

Name of health care professional (print or type): _____ Date of exam _____

Address: _____ Phone: _____

Signature: _____ MD/DO/NP/PA

Athletes must upload completed forms to: https://wne.medicatconnect.com/home.aspx