



The University of Akron Pre-Participation Physical Form

Name: _____ Sex: _____ Age: _____ Date of Birth: _____
 Year in School: Fresh Soph Junior Senior 5th Sport(s): _____
 Campus Address: _____ Home/Room Phone: _____
 Cell Phone: _____ Personal/Family Physician: _____ Phone: _____
In case of emergency, contact: Name _____
 Relationship: _____ Home Phone: _____ Work: _____ Cell: _____

Explain "Yes" answers below. Circle questions that you do not know the answer to.

1.	Has a doctor ever denied or restricted your participation in sports for any reason?	Yes No <input type="checkbox"/> <input type="checkbox"/>		23.	Do you cough, wheeze or have difficulty breathing during exercise?	Yes No <input type="checkbox"/> <input type="checkbox"/>																
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/> <input type="checkbox"/>		24.	Is there anyone in your family who has 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"/>		25.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/> <input type="checkbox"/>																
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/> <input type="checkbox"/>		26.	Were you born without or are you missing a kidney, eye, a testicle or any other organ?	<input type="checkbox"/> <input type="checkbox"/>																
5.	Do you think you are in good health?	<input type="checkbox"/> <input type="checkbox"/>		27.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/> <input type="checkbox"/>																
6.	Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/> <input type="checkbox"/>		28.	Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/> <input type="checkbox"/>																
7.	Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/> <input type="checkbox"/>		29.	Have you had a herpes skin infection?	<input type="checkbox"/> <input type="checkbox"/>																
8.	Have you ever had discomfort, pain or pressure in your chest during exercise?	<input type="checkbox"/> <input type="checkbox"/>		30.	Have you ever had a head injury or concussion?	<input type="checkbox"/> <input type="checkbox"/>																
9.	Does your heart race or skip beats during exercise?	<input type="checkbox"/> <input type="checkbox"/>		31.	Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/> <input type="checkbox"/>																
10.	Has your 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			32.	Have you ever had a seizure?	<input type="checkbox"/> <input type="checkbox"/>																
11.	Has a doctor ever ordered a test for your heart? (Ex, ECG, Echocardiogram)	<input type="checkbox"/> <input type="checkbox"/>		33.	Do you have headaches with exercise?	<input type="checkbox"/> <input type="checkbox"/>																
12.	Has anyone in your family died for no apparent reason?	<input type="checkbox"/> <input type="checkbox"/>		34.	Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/> <input type="checkbox"/>																
13.	Does anyone in your family have a heart problem?	<input type="checkbox"/> <input type="checkbox"/>		35.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/> <input type="checkbox"/>																
14.	Has a family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/> <input type="checkbox"/>		36.	When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/> <input type="checkbox"/>																
15.	Does anyone in your family have Marfan Syndrome?	<input type="checkbox"/> <input type="checkbox"/>		37.	Has a doctor told you that you or someone in your family has sickle cell disease?	<input type="checkbox"/> <input type="checkbox"/>																
16.	Have you ever spent the night in a hospital?	<input type="checkbox"/> <input type="checkbox"/>		38.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/> <input type="checkbox"/>																
17.	Have you ever had surgery?	<input type="checkbox"/> <input type="checkbox"/>		39.	Have you had any problems with your eyes or vision?	<input type="checkbox"/> <input type="checkbox"/>																
18.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss practice or game? If yes, circle affected area below:	<input type="checkbox"/> <input type="checkbox"/>		40.	Do you wear glasses or contact lenses?	<input type="checkbox"/> <input type="checkbox"/>																
19.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/> <input type="checkbox"/>		41.	Do you regularly use a brace or assistive device?	<input type="checkbox"/> <input type="checkbox"/>																
20.	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: <table border="1" style="margin: 5px auto; border-collapse: collapse; text-align: center;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper Arm</td> </tr> <tr> <td>Upper Back</td> <td>Lower Back</td> <td>Hip</td> <td>Thigh</td> </tr> <tr> <td>Elbow</td> <td>Forearm</td> <td>Hand/Fingers</td> <td>Chest</td> </tr> <tr> <td>Knee</td> <td>Calf/Shin</td> <td>Ankle</td> <td>Foot/Toes</td> </tr> </table>	Head	Neck	Shoulder	Upper Arm	Upper Back	Lower Back	Hip	Thigh	Elbow	Forearm	Hand/Fingers	Chest	Knee	Calf/Shin	Ankle	Foot/Toes	<input type="checkbox"/> <input type="checkbox"/>		42.	Are you happy with your weight?	<input type="checkbox"/> <input type="checkbox"/>
Head	Neck	Shoulder	Upper Arm																			
Upper Back	Lower Back	Hip	Thigh																			
Elbow	Forearm	Hand/Fingers	Chest																			
Knee	Calf/Shin	Ankle	Foot/Toes																			
				43.	Are you trying to gain or lose weight?	<input type="checkbox"/> <input type="checkbox"/>																
				44.	Do you limit or carefully control what you eat?	<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 have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/> <input type="checkbox"/>																
				47.	Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/> <input type="checkbox"/>																
				48.	FEMALES ONLY 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 last 12 months? ____																	
				Explain "Yes" answers here: _____ _____ _____ _____																		
21.	Have you ever had a stress fracture?	<input type="checkbox"/> <input type="checkbox"/>																				
22.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/> <input type="checkbox"/>																				

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: _____ Date: _____
Athlete/Parent or Guardian

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name: _____ Birth Date: _____
Height: _____ Weight: _____ % Body Fat: _____ Pulse: _____ BP: _____/_____, _____/_____, _____/_____
Vision R 20/____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

MEDICAL	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Notes: _____

CLEARANCE

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

Not cleared for : All Sports Certain Sports: _____ Reason: _____

Recommendations: _____

Emergency Information:

Allergies: _____

Other Information: _____

Name of Physician: (Print) _____ (M.D., D.O., D.C.) Date: _____