Name:_____ ASU ID:_____ Date of Birth:_____

Arizona State University

PRE-PARTICIPATION PHYSICAL

2021 - 2022

Health Services Sports Medicine

Phone: (480) 965 - 3349
https://eoss.asu.edu/health

General Medical History

	(please circle):	
Has a doctor ever told you that you cannot compete in sports for any reason?	Yes	No
Do you have any ongoing medical conditions (like asthma, diabetes, other)?	Yes	No
Are you missing a kidney, eye, a testicle (males), spleen, or any other organ?	Yes	No
Do you have any allergies to medicine, food, or insects?	Yes	No
If yes, list reaction: _____		
Are you currently taking any medicine or supplements?	Yes	No
Medicine: _____ Reason for taking it: _____		
Medicine: _____ Reason for taking it: _____		
Have you ever had mononucleosis?	Yes	No
Date: _____		
Have you ever had COVID-19 ?	Yes	No
Date: _____		
Do you have any other medical issues - either now or in the past?	Yes	No

Explain any **YES** answer: _____

Family History

Are there any family members who died before age 50? Yes No

Please list any other major medical problems affecting your parents, brothers, or sisters:

_____

Are there any family members with conditions that can affect the heart such as:

Enlarged heart	Yes	No
Hypertrophic Cardiomyopathy	Yes	No
Dilated Cardiomyopathy	Yes	No
Long QT syndrome	Yes	No
Short QT syndrome	Yes	No
Brugada syndrome	Yes	No
Catecholaminergic Polymorphic Ventericular Tachycardia	Yes	No
Arrythmogenic Right Ventricular Cardiomyopathy	Yes	No
Marfan syndrome	Yes	No
Heart attack, age 50 or younger	Yes	No
Pacemaker or defibrillator, age 50 or younger	Yes	No

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Your Cardiac History

Have you ever been dizzy during or after exercise?	Yes	No
Have you ever passed out during or after exercise?	Yes	No
Have you ever had chest pain with exercise?	Yes	No
Does your heart race or skip beats during exercise?	Yes	No
Do you ever get short of breath with exercise?	Yes	No
Do you get tired or short of breath more quickly than your friends?	Yes	No
Has a doctor ever ordered a heart test (EKG, Echo)?	Yes	No

Have you ever been told that you have:

a heart murmur?	Yes	No
high blood pressure ?	Yes	No
a heart infection (myocarditis)?	Yes	No
Kawasaki disease?	Yes	No
high cholesterol?	Yes	No

Concussion/Neurologic History

Have you ever had a head injury, concussion, saw stars, had your “bell rung”?	Yes	No
If yes, when (aproximate date(s)): _____		
If yes, have you 100% fully recovered?	Yes	No
Have you ever been knocked out, blacked out, or unconscious?	Yes	No
Have you ever had a stinger or burner?	Yes	No
Have you ever lost feeling or couldn't move an arm or leg?	Yes	No
Have you ever had a seizure?	Yes	No

Respiratory History

Do you have asthma?	Yes	No

If yes, how often do you use Albuterol inhaler or “puffer” (circle):
throughout the day | once a day | more than 2 days/week | less than 2 days/week |exercise only

Do you cough, wheeze, or have trouble breathing during or after exercise?	Yes	No
Have you ever been given a daily medication for asthma or breathing issues?	Yes	No

Heat Illness History

Have you ever had any exercise related heat cramps or heat stroke?	Yes	No
Have you ever needed to get IV Fluids due to the heat?	Yes	No

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Behavioral Health Screening

In the last 2 weeks, how often have you been bothered by any of the following problems? (circle)

	Not at all	Some days	Most days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Do you make yourself sick because you feel uncomfortably full? Yes No
So you worry you have lost control over how much you eat? Yes No
Hove you recently lost more than 14 pounds in a three month period? Yes No
Do you believe yourself fat when others say you are too thin? Yes No
Would you say that food dominates your life? Yes No

Circle the answer that best applies to you: 0 1 2 3 4

How often do you have a drink continaing acohol?	Never	Monthly or less	2-3 times a month	2-3 times a week	4 + times a week
How many standard drinks do you have on a typical day when drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +
How often do you have 6 or more drinks?	Never	Less than monthly	Monthly	Weekly	Daily

Do you use tobacco? Yes No
If yes:
Type (vape/cigarrettes/chew)? _____

Do you use marijuana? Yes No
If yes:
Type (vape/smoke)? _____

Sexual History

Have you ever had sexual activity another person? Yes No

If yes:
When you have engaged in sexual activity, what sex has/have your sexual partner(s) been? (circle)
Opposite sex (male with female, female with male)
Same sex (female with female, male with male)
Multiple sexes (sometimes called bisexual/pansexual)

How many different sexual partners have you had:
In the past year: _____ In your entire life: _____

Have you ever beend diagnosed with a sexually transmitted infection? Yes No

If yes, which infection(s)? _____

Do use condoms or barriers for sexual activity? Always Sometimes Never

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Vaccine History

	Received:	Year:		Received:	Year:
Tetanus (within 10 years)	Y / N	_____	HPV	Y / N	_____
Menigitis ACWY (booster after 16)	Y / N	_____	Influenza (each fall)	Y / N	_____
Menigits B (up to age 24)	Y / N	_____	COVID-19	Y / N	_____

Injury History

Please list any significant injuries (symptoms or time off for more than 1 week):

Body Region	Sprain / Strain / Fracture / Other	Year	Right / Left	Management / Treatment / Outcome
Head				
Neck/Back				
Hand/Wrist				
Elbow				
Shoulder				
Hip				
Knee				
Ankle				
Foot				

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

Student signature: Date:

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To be completed by the examining clinician and provided to the student

Please choose one and initial:

_____ Medically eligible for all sports without restriction.

_____ Not medically eligible pending further evaulation and consultation with ASUHS Sports Medicine.

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the student. If conditions arise after the athlete has been cleared for participation, the clinician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the student.

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

Credential (circle): MD DO NP

Clinic Name: _____

Address: _____

Phone: _____

Signature of clinician: _____ Date: _____