

Seattle Pacific University
 Pre-participation Physical Evaluation (Side Two)
Physical Examination & Clearance Form
 (to be filled in by Physician)

Name _____ Date of Birth _____

Sport(s) _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____/____ (____/____, ____/____)

Vision R 20/ ____ L 20/ ____ Corrected: Y N Pupils: Equal ____ Unequal ____

Follow-up Questions:	Yes	No
1. Do you feel stressed out or under a lot of pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel safe?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken steroid pills or shots without a doctor's prescription?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Notes: _____

ATHLETICS PARTICIPATION

- Cleared Without Restrictions
- Cleared With Recommended Evaluation Or Treatment: _____
- _____
- Not Cleared. Reason/Recommendation: _____
- _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD/DO/PA/ARNP

Seattle Pacific University
Pre-participation Physical Evaluation (Side One)
Medical History Form
 (to be filled out by Athlete prior to Physical Exam)

Name _____ Sport(s) _____
 Sex _____ Age _____ Date of Birth _____ Phone _____
 Permanent Address _____
 In case of emergency, contact: Name _____ Phone (H) _____ (C) _____ (W) _____
 Relationship _____ Personal Physician _____ Phone _____

Circle questions you don't know the answer to. Explain "Yes" answers at end.

- | | 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 non-prescription 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 hear 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? (e.g. ECG/EKG/Electrocardiogram) | <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/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 (e.g. sprain, muscle or ligament tear, or tendonitis) 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 been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 25. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you ever had a head injury or concussion? | <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"/> |
| 32. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Do you have headaches with exercise? | <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"/> |
| 35. Have you ever been unable to move your arms or legs after being hit or falling? | <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"/> |
| 37. 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"/> |
| 38. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES ONLY

46. How old were you when you had your first menstrual period? _____
 47. How many periods have you had in the last year? _____

Explain "Yes" answers here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I hereby authorize the release of the medical information on both sides of this form to the SPU Athletic Department.

Signature of Athlete _____ Date _____