



**MID-AMERICA CHRISTIAN UNIVERSITY
STUDENT ATHLETE PRE-PARTICIPATION PHYSICAL EXAMINATION**

Name: _____ Date: _____ Sport: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: _____ SSN: _____ Cell Phone Number: _____
 Year in school: FR SO JR SR 5th
 LIST OF CURRENT MEDICATIONS: _____
 ALLERGIES: _____ REACTIONS: _____

The following information will be kept confidential. It is intended for use by MACU medical personnel only. Select the appropriate answers to each question and provide written clarification where indicated.

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Had a serious injury / been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have you been diagnosed with a heart murmur?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Had a sprain / strain and/or fracture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Do you have any allergies?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Had a concussion and/or head injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Are you taking any dietary/nutritional supplements, vitamins, creatine, amino acids, or any herbal remedies? If so, please list.
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Been unconscious for any other reason other than anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Had an unfavorable / allergic reaction to a drug, antibiotic, and/or medicine?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Had a neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Do you take any medications for pain or a medical condition on a regular basis (> 3 days a week)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Had a back injury or suffered from back pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Do you have any ongoing or chronic illnesses?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Had any burners, stingers, numbness in neck, shoulder, and/or hand?	<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Had frequent headaches?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Had a shoulder, elbow, hand or wrist injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Had a dental injury?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Had a hip and/or knee injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Had an operation?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Had a lower leg, ankle, and/or foot injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	28. Do you wear contact lenses, glasses, and/or safety glasses?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Missed a practice and/or game due to an injury and/or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	29. Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorder?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Been diagnosed with any NEW injuries and/or medical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	30. Had a heat related illness (heat cramps, heat exhaustion, and/or heat stroke) and/or missed time / received special attention (IV fluids, etc.) for a heat related problem?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Are you currently undergoing physical therapy or rehabilitation for an injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	31. Have you been diagnosed with sickle cell anemia or sickle cell trait?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Been evaluated by a MACU Team Physician and/or other physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	32. Do you require any special equipment to participate in athletics?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. While exercising, has your heart ever "skipped" a beat, have you suffered from a "racing heart", severe chest pain, lightheadedness, or fainted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	33. Have you been told by a physician to restrict your activity or not to participate in sport?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever felt dizzy, passed out, or "blacked out" during or after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	34. Been recently diagnosed with infectious mononucleosis ("mono"), hepatitis B or C, HIV/AIDS, and/or any other severe infectious disease / viral infection?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Experienced coughing, wheezing, shortness of breath, or breathing difficulties during or after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	35. Been denied clearance by a medical professional to participate in any athletic activity?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Have you been diagnosed with asthma or exercise induced asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	36. Do you take any medications on a regular basis? If so, please list.

FEMALES ONLY!

When did your last menstrual period begin? _____
 How long does your menstrual period usually last? _____
 How many menstrual periods have you had in the last 12 months? _____
 Do you take birth control pills? If so, which one(s)? _____

If you answered "YES" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form, please explain in detail below (use additional sheet(s) if necessary).

I, the undersigned, hereby acknowledge, affirm, and represent that all above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature _____

Date _____

Vital Information:

Height _____

Weight _____

Blood Pressure _____ / _____

Pulse _____

Physical Exam *(to be completed by the physician)-*

	NORMAL	ABNORMAL FINDINGS
MEDICAL	<input type="checkbox"/>	
Appearance	<input type="checkbox"/>	
Eyes/Ears/Throat	<input type="checkbox"/>	
Lymph Nodes	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	
Pulses	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Genitalia (Male only)	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	
MUSCULOSKELETAL	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder/Arm	<input type="checkbox"/>	
Elbow/Forearm	<input type="checkbox"/>	
Wrist/Hand	<input type="checkbox"/>	
Hip/Thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg/Ankle	<input type="checkbox"/>	
Foot	<input type="checkbox"/>	

Recommendations / Comments: _____

Status:

- Pass without Restrictions
- Pass with Restrictions _____
- Further Evaluation Needed _____

_____ Examiner's Signature	_____ Date
_____ Examiner Print Name	