

Southern Oregon University Athletics
Health History and Physical Examination

Name _____ Sex _____ Date _____
Social Security # _____ Date of Birth _____ Age _____
Sport(s) _____ Position(s) _____ Eligibility year RFR FR SO JR SR

Completed by the Athlete:

Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications/insect stings/food? YES NO

◆ Please Describe _____

Have you ever had chest pain and/or shortness of breath during or after exercise / practice? YES NO

◆ Please Describe _____

Have you ever been told that you have a heart murmur? YES NO

◆ Please Describe _____

Has any family member or relative died of heart problems and/or of sudden death before age 50? YES NO

◆ Please Describe _____

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? YES NO

◆ Please Describe _____

Have You Ever Been Diagnosed With Diabetes? YES NO

◆ Date? _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes? YES NO

◆ Please Describe _____

Have You Ever Been Diagnosed With Asthma and/or Exercised Induced Asthma? YES NO

◆ Please Describe _____

Have you had a severe viral infection (myocarditis, mononucleosis, etc.) within the last month? YES NO

◆ Please Describe _____

Have You Ever Been Diagnosed With A Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphillis, Tuberculosis)?

YES NO

◆ List Dates/Time Missed _____

◆ Please Describe _____

Have You Ever Had Problems Related To A Hernia, Kidney, Bladder, or Ulcer? YES NO

◆ Please Describe _____

Have You Had A Loss Or Serious Impairment Of A Paired Organ (Kidney, Liver, Eye) YES NO

◆ Please Describe _____

Have You Ever Suffered A Head Injury / Concussion (no matter how minor)? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? YES NO (check all that apply)

X-ray MRI CT-Scan Neuropsychological Testing Other _____

Have You Ever Been Hospitalized, Knocked Out, Become Unconscious, and/or Lost Your Memory Due To A Head Injury / Concussion?

YES NO

◆ Please Describe _____

Do You Suffer From Headaches?

YES NO

When? Every Day 1-2 Times/Week 1-2 Times/Month

Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease?

YES NO

◆ Please Describe _____

Do you routinely wear glasses?

YES NO

Do you routinely wear contact lenses?

YES NO

Type _____

Do you require any special devices / equipment?

YES NO

Type _____

Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat?

YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth?

YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck?

YES NO

◆ Please Describe _____

Have You Ever Had "Burners", "Stingers", or Brachial Plexus Injuries?

YES NO

◆ How Many? _____ Date(s)/Time Missed? _____

Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck?

YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Shoulder / Upper Arm?

YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Elbow / Forearm?

YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)?

YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint? YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Rib / Thorax / Chest?

YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Hip / Groin (*including hernias and/or sports hernias*)?

YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps?

YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)?

YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Knee and/or Patella Injury? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Ankle / Lower Leg? YES NO

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Foot / Toe(s)? YES NO

◆ Please Describe _____

Have You Ever Suffered From A Heat Related Injury? YES NO (check all that apply):

◆ Heat Cramps- Date(s)? _____

◆ Heat Syncope (Fainting)- Date(s)? _____

◆ Heat Exhaustion- Date(s)? _____

◆ Heat Stroke- Date(s)? _____

Have You Ever Been Hospitalized For a Heat-Related Problem? YES NO

◆ Date(s)? _____ Where? _____

Please List any problems, illnesses, or medical concerns not mentioned above:

XXVII. For Females Only:

At what age did you have your first menstrual period? _____

YES NO Have you had menstrual periods within the past 12 months?

◆ If yes, how many? _____ When was your most recent menstrual period? _____

YES NO Do you have painful or heavy menstrual periods?

YES NO Do you take any medications during your menstrual periods? If yes, what? _____

YES NO Do you take birth control pills?

YES NO Have you ever had any problems with your breasts?

YES NO Have you had a pelvic examination within the last year?

Immunization records:

Measles (Rubeola) or MMR: #1 _____ #2 _____ Last tetanus _____ Chicken Pox _____ Hepatitis B _____

I hereby state that I have fully and completely disclosed and described every part of my medical history of which I have knowledge. Further, I have fully and completely disclosed any and all past and preexisting injuries, congenital defects, and any and all ailments that would potentially cause me to be unable to perform as a player. As to all of the above which I have not made full and complete disclosure, I hereby waive my rights to any and all claims against Southern Oregon University, the Athletic Department and their employees, and the Team Physicians for medical expenses and any or all other claims.

Athlete's Signature _____ Date _____

Pre-Participation Physical Examination

Completed by a Licensed Physician (MD or DO)

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP _____ / _____ Vision R 20/ _____ L 20/ _____ Contacts YES NO

	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/Ankle		
Foot		

Cleared For Athletic Participation

Cleared After Completing Evaluation/Rehabilitation For: _____

Limited Participation: _____ Reasons: _____

Not Cleared Recommendations: _____

Name of Physician (print/type/stamp) _____

Date _____

Address _____

Phone _____

Signature of Physician _____ (MD or DO)