University at Albany Pre-participation questionnaire- (2 pages)

Name___________________________ Sport________________ Date___/___/____
Albany ID#______________________ DOB /__/___ Cell Phone Number__________

Medications & supplements_________________________________________ [ ] NONE
Medication Allergies_______________________________________________ [ ] NONE
Other (environmental) Allergies________________________________________ [ ] NONE
Tetanus immunization within 10 years YES NO Don’t know

Have you ever had surgery or been hospitalized overnight? YES NO
Have you ever been denied participation in athletics for a medical reason? YES NO
Have you had an injury or medical illness, since your last physical, that has required you to see a physician? YES NO
Have you had mononucleosis within the past two months? YES NO
Do you use any special braces or other protective equipment while participating in sports? YES NO
Have you had Chicken Pox OR been vaccinated against Chicken Pox? YES NO

Are you missing an eye, kidney, testicle, ovary or lung? YES NO
Have you ever suffered from a heat related illness (heat stroke, heat cramps or heat exhaustion) YES NO

NEURO:
History of seizures? YES NO
Head injury requiring medical evaluation? YES NO
Headaches severe enough to interfere with athletics? YES NO
Ever have a “stinger” or “burner”? YES NO
Have you ever had a Concussion? YES NO

If yes:
Number of concussions________________
Approximate date of most recent________________
Approximate age at time of first concussion________________
Concussion symptoms ever last longer than 3 days? YES NO
Any Loss of Consciousness? YES NO
Any Amnesia? YES NO
Any convulsions? YES NO
Any Mental Health/psychiatric diagnosis? YES NO

EYES:
Need corrective lens with sports participation? YES NO
ANY eye problems (other than vision correction) requiring treatment by an ophthalmologist (eye doctor)? YES NO

RESPIRATORY:
Difficulty breathing with exercise which is more severe than expected for your level of fitness? YES NO
Use inhalers for exercise associated asthma? YES NO

(Continued on next page)
Name_________________  DOB / /  Sport________  Date / / 

CARDIAC:
- Has a doctor ever told you that you have a heart murmur? YES NO
- Have you ever passed out or nearly passed out during exercise? YES NO
- Have you ever passed out or nearly passed out after exercise? YES NO
- Does your heart race or skip beats during exercise? YES NO
- Have you ever had discomfort, pain, or pressure in your chest during exercise? YES NO
- Has a doctor ever ordered a test on your heart (for example EKG, echocardiogram)? YES NO
- Has a family member or relative died of heart problems or sudden death before age 50? YES NO
- Has anyone in your family died from no apparent reason? YES NO
- To the best of your knowledge, any relative’s with:
  - Marfan’s Syndrome? YES NO
  - Enlarged Heart? YES NO
  - Long Q-T syndrome? YES NO
  - Abnormal Heart Rhythm? YES NO
- Ever have **myocarditis** (infection of the heart muscle)? YES NO

BLOOD:
- Ever been treated or diagnosed with Anemia? YES NO
- Ever been diagnosed with a bleeding disorder (such as Von Willebrand’s)? YES NO
- Ever diagnosed with Sickle Cell (trait or disease)? YES NO
- If sickle status unknown; would you participate in a **VOLUNTARY** sickle screening test? YES NO

NOTE: Cost of testing is covered by the Athletic Department (no cost to students). Most States require testing at birth with the expectation the physician of record would notify parents of positive sickle trait/disease shortly after birth. Blacks, and those of Middle Eastern or Indian descent are most at risk to have sickle cell trait though anyone can have sickle trait. Sickle trait (without disease) places athletes at risk of sudden death, exercise related muscle damage (rhabdomyolysis) and splenic infarct.

SKIN:
- Currently have any rashes? YES NO
- Ever been denied athletic participation because of a skin condition? YES NO

MUSCULOSKELETAL:
- Ever break a bone (fracture) or dislocate a joint? YES NO
- Any known spine problems? YES NO
- Any neck injuries requiring a physician’s evaluation? YES NO
- Any joint problems requiring a physician’s evaluation? YES NO
- Ever have low back pain severe enough to prevent athletic participation? YES NO
- Any previous injuries which cause you problems now? YES NO

FEMALES ONLY:
- Are you currently having at least 9 menses (periods) per year? YES NO
- Have you ever been treated for an eating disorder? YES NO

Athlete’s signature_________________________________________ Date: / / 

(Parent Signature for Athlete’s less than 18 years of age)

Signature acknowledges all questions answered truthfully and the best of the signee’s knowledge

DO NOT WRITE BELOW THIS LINE—OFFICIAL USE ONLY

Reviewer’s comments:________________________________________

Reviewer signature________________________ Date / / No issues Medical Ortho
UAlbany PPE PHYSICAL

Name_______________________________ DOB ___/___/____ Date ___/___/____

Height _______Weight _______ HR _______ BP _____/______ Vision R 20/ __ L 20/ __

Last Td.________________________________________

Appearance NL ABNL/comments
Skin[]

EENT[]

Lymph[]

Lungs[]

Abdomen[]

Genitalia(males only)[]

CARDIOVASCULAR:

Femoral pulses intact[]

Heart sounds (performed in standing & supine position)
 Normal[]
 Physiologic splitting of S2[]
 Absence of murmurs[]

Absence of murmur with:
(at least one)
  squat to stand[]
  valsalva[]

MUSCULOSKELETAL

NECK[]

BACK (no scoliosis)[]

SHOULDER[]

ELBOW[]

WRIST/HAND[]

DUCK WALK[] (If abnormal, complete hip, knee & ankle exam is mandatory)

HIP[]

KNEE[]

ANKLE[]

Marfan stigmata (Male over 6 ft./Female over 5 ft 10in.) NONE NOTED[]
  [] myopia [] kyphoscoliosis [] Anterior thoracic def.
  [] arm span > height AS/HT > 1.05 [] wrist sign [] thumb sign [] US/LS < 0.86 (LS= SP-Floor)

Signature

(FLIP OVER)
CLEARANCE: 

[] CLEARED
[] CLEARED with mildly elevated BP reading. Recommended recheck at HC
[] CLEARED with the following recommendations:
__________________________________

[] CLEARED temporarily pending further evaluation of
__________________________________

[] CLEARED pending obtainment of additional medical records
__________________________________

[] NOT CLEARED
for(sport)____________________ Reason:_________________________________
__________________________________

Signature________________________________________
__________________________________

Division of Student Affairs
Student Health Services
400 Patroon Creek, Suite 200, Albany, NY 12206
PH: 518-442-5454  FX: 518-442-5444
www.albany.edu