REQUIRED BY ALL INTERCOLLEGIATE ATHLETES
PREPARTICIPATION PHYSICAL EXAMINATION
BLUFFTON UNIVERSITY

(Athletes may not practice or participate in any sport until the PreParticipation Physical Examination has been completed **ON** or **AFTER June 1st** of the upcoming academic year and received by the university.)

Date:_____/_____/_____ Name:_____ Sport:_____

Date of Birth:_____/_____/_____ Sex: M_____ F_____ Year in Sport: 1 2 3 4 5

Family Doctor: _____ Doctor's Phone: (_____) _____

Doctor's Address: _____

MEDICAL HISTORY (to be completed by student)

Please answer the following questions in as much detail as possible.

Please check the appropriate box. Please comment on all Yes answers.

	(Y)	(N)	Comments
Have you had a medical illness or injury since your last physical?	( )	( )	_____
Have you ever:			
Been hospitalized or had any surgery?	( )	( )	_____
Broken a bone?	( )	( )	_____
Taken any vitamins or supplements to help you gain or lose weight or improve your performance?	( )	( )	_____
Had a physician restrict your participation in sports for any reason?	( )	( )	_____
Had any ongoing or chronic illness?	( )	( )	_____
Has anyone in your immediate family ever had:			
Diabetes (high blood sugar)?	( )	( )	_____
Sudden death (age less than 50)?	( )	( )	_____
High blood pressure?	( )	( )	_____
Heart attack (age less than 50)?	( )	( )	_____
Marfan's syndrome?	( )	( )	_____
Other heart problems?	( )	( )	_____
Asthma	( )	( )	_____
High cholesterol?	( )	( )	_____
Have you ever had or do you now have:			
Chest pain with or after exercise?	( )	( )	_____
Dizziness with or after exercise?	( )	( )	_____
High blood pressure?	( )	( )	_____
Racing of the heart/irregular rhythm?	( )	( )	_____
Heart murmur?	( )	( )	_____
Passed out with exercise?	( )	( )	_____
High cholesterol?	( )	( )	_____
Severe heart infection (e.g. myocarditis, pericarditis)?	( )	( )	_____
Wheezing/cough with exercise, asthma?	( )	( )	_____
Seasonal allergies that require medical attention?	( )	( )	_____
Weakness, fatigue, or anemia?	( )	( )	_____
Hearing loss?	( )	( )	_____
Headaches or migraines?	( )	( )	_____
Head injury or concussion?	( )	( )	_____
Loss of consciousness or memory loss?	( )	( )	_____
Seizures/convulsions?	( )	( )	_____
"Stinger", "burner", or "pinched nerve"?	( )	( )	_____
Dental plate or orthodontic work?	( )	( )	_____
Impaired vision, wear glasses/contacts?	( )	( )	_____
Heat exhaustion or intolerance?	( )	( )	_____
Frequent anxiety, depression, insomnia?	( )	( )	_____
Weight problem (or recent weight gain/loss)?	( )	( )	_____

List any current medications (include over the counter and birth control pills, vitamins, supplements and inhalers)

_____

List any allergies to medication:_____

Have you ever had a neck injury of any kind? ( ) ( ) _____
Have you ever had any back injury/pain? ( ) ( ) _____
Have you ever sustained a shoulder injury? ( ) ( ) _____
(If Yes, indicate type of injury, shoulder and dates.) _____
Have you ever sustained a knee injury? ( ) ( ) _____
(If Yes, indicate type of injury, knee and dates.) _____
Have you ever worn a special brace, or had modifications made in equipment worn? ( ) ( ) _____
(If Yes, indicate reason, duration worn.) _____
Have you ever had a stress fracture? ( ) ( ) _____
Have you ever been treated for emotional problems? ( ) ( ) _____
Do you have any other medical or physical condition not mentioned? ( ) ( ) _____

Females:
Have you ever had or do you now have menstrual irregularities or absence of menses? ( ) ( ) _____
Longest time between periods in last year. _____

To the best of my knowledge, the above information is accurate. By signing this form, I agree that pertinent medical information concerning my health may be shared among the Bluffton University coaching staff, training staff, team physicians, and the Bluffton University Student Health Center.

_____
Student Signature

_____

PHYSICAL EXAMINATION

(to be completed by Physician - M.D. or D.O. ONLY; or CO-SIGNED by M.D. or D.O.)

Date: _____/_____/_____ Name: _____

Blood Pressure: _____ Pulse: _____ Height: _____ Weight: _____

Vision: R 20/_____ L 20/ _____ Corrected: Yes / No

	Nml	Abnml	Comments
HEENT	( )	( )	_____
Cardiac	( )	( )	_____
Lungs	( )	( )	_____
Skin	( )	( )	_____
Abdominal	( )	( )	_____
Genitalia	( )	( )	_____
Upper Extremity Joints	( )	( )	_____
Lower Extremity Joints	( )	( )	_____
Spine & Musculature	( )	( )	_____

Other_____

I certify that I have reviewed the history and examined the above student and I recommend:

_____Clearance with no limitations.
_____Clearance pending further evaluation or testing (Please explain)
_____Referral to other health care professional prior to clearance. (Please explain)
_____Clearance with limitations (Please explain)
_____Disqualified from competition. (Please explain)

Comments:
_____
_____
_____
_____
_____
(*Continue explanation on additional sheet if needed.)*

Name of Examining Physician _____ Phone: (_____) _____

Address: _____

_____

Signature: _____ Date: _____

Please return to*:*

Bluffton University, Athletic Office, 1 University Drive, Bluffton, OH 45817-2104