



# Kalamazoo College Pre-participation Physical Evaluation Form

Exam Date \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sport \_\_\_\_\_ Land Sea: Y N  
Home Address \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Email Address \_\_\_\_\_ Cell Phone # \_\_\_\_\_

**FAMILY HISTORY:** Please list any of your immediate family that has been diagnosed with the following.

Alcoholism \_\_\_\_\_ Anxiety \_\_\_\_\_ Epilepsy/Seizures \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Stroke \_\_\_\_\_  
Heart Disease \_\_\_\_\_ High Cholesterol \_\_\_\_\_ Diabetes \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Depression \_\_\_\_\_  
Cancer (list type) \_\_\_\_\_ Other \_\_\_\_\_

**Please answer all of the questions. Those that you answer "yes" EXPLAIN in the space below.**

## MEDICAL HISTORY

## MEDICAL HISTORY CONT.

1. When was your last physical? \_\_\_\_\_
2. Have you had any illness or injuries since your last physical? Y N
3. Do you have any ongoing or chronic illness? Y N
4. Have you ever been hospitalized overnight? Y N
5. Have you ever had surgery? Y N
6. Do you have any allergies? Y N
7. Have you ever been dizzy or passed out, or nearly passed out during or after exercise? Y N
8. Have you ever had chest pain during or after exercise? Y N
9. Have you ever had racing of your heart or skipped beats of your heart? Y N
10. Have you ever been told you have a heart murmur? Y N
11. Has a physician ever denied or restricted your participation in sports for any heart problems? Y N
12. Have you ever had high blood pressure or cholesterol? Y N
13. Have you ever had a viral infection (i.e.: mononucleosis or myocarditis) in the last month? Y N
14. Have you ever had a seizure? Y N
15. Do you have frequent or severe headaches? Y N
16. Have you ever had a head injury or concussion? Y N
17. Have you ever been knocked out or lost your memory? Y N
18. Have you ever had a stinger, burner, or pinched nerve? Y N
19. Have you ever become ill from exercising in the heat? Y N
20. Do you cough, wheeze, or have trouble breathing during exercise? Y N
21. Do you have asthma? If so, do you use an inhaler? \_\_\_\_\_ Y N

22. Do you have hyperglycemia or hypoglycemia? Y N
23. Has a doctor told you or someone in your family has sickle cell trait or sickle cell disease? Y N
24. Are you currently taking prescription or nonprescription medications? \*NCAA requires on-site documentation re: ADHD diagnosis and medication prescriptions. PLEASE PROVIDE Y N
25. Have you ever taken supplements to help gain or lose weight or to improve performance? Y N
26. Do you have any skin problems (i.e.: rash, warts, itching)? Y N
27. Have you had any problems with your eyes or vision? Y N
28. Do you wear glasses, contacts, or protective eyewear? Y N
29. Have you ever had a ligament sprain or a muscle strain? Y N
30. Have you fractured any bones or dislocated any joints? Y N  
If yes, check appropriate area and explain.  
\_\_\_ Head \_\_\_ Neck \_\_\_ Back \_\_\_ Chest \_\_\_ Shoulder  
\_\_\_ Elbow \_\_\_ Hand \_\_\_ Arm \_\_\_ Wrist \_\_\_ Thigh  
\_\_\_ Hip \_\_\_ Knee \_\_\_ Tibia/Fibula \_\_\_ Foot/Ankle
31. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Y N
32. Have you ever had problems with or treated for drug and/or alcohol abuse? Y N
32. Please list when the following immunizations were administered:  
Measles, mumps, rubella (MMR) \_\_\_\_\_  
Hepatitis B \_\_\_\_\_  
Diphtheria \_\_\_\_\_  
Tetanus \_\_\_\_\_  
Meningitis \_\_\_\_\_

**Note: Your immunization form from the health center MUST BE turned in prior to your arrival on campus or you WILL NOT be allowed to move into your dorm room!!!**

**Explain yes answers here:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Information withheld, incomplete, or incorrect may result in incomplete or incorrect medical treatment and may disqualify you from participation on any Kalamazoo College athletic team.**

**I hereby state that, to the best of my knowledge, my answers to the above questions are correct and accurate.**

**Athlete's/Land Sea Participants Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Guardian if Under 18** \_\_\_\_\_



# Kalamazoo College Pre-participation Physical Evaluation Form Cont.

Name \_\_\_\_\_

Sport \_\_\_\_\_ / Land Sea: Y N

## MEDICAL HISTORY CONTINUED

33. Are you currently, or in the past year, followed a particular diet? 33. Y N
34. How many meals (ie breakfast, lunch, dinner) do you eat a day? \_\_\_\_\_
35. How many snacks? \_\_\_\_\_
36. Are there certain food groups that you refuse to eat? (meats, breads, etc) \_\_\_\_\_ 36. Y N
37. Do you ever limit food intake to control weight? 37. Y N  
If yes, do you (circle) Decrease the amount of food you eat during the day/ skip meals/ limit carbohydrate intake/ limit fat intake/ cut out snacks/  
Other \_\_\_\_\_
38. Do you ever feel out of control when eating or feel that you can't stop? 38. Y N
39. Do you take vitamin supplements? 39. Y N  
If yes, what type? \_\_\_\_\_ How often? \_\_\_\_\_
40. Do you take nutritional supplements? 40. Y N  
If yes, what type? \_\_\_\_\_ How often? \_\_\_\_\_
41. Do you gain or lose weight regularly to meet the demand of your sport? 41. Y N
42. Has anyone recommended that you change your weight or eating habits? If yes, specify (coach, parent, friend) \_\_\_\_\_ 42. Y N
43. Has anyone ever set a target weight for you or subjected you to routine weigh-ins? 43. Y N
44. Have you ever tried to lose weight by using any of the following methods? (circle) vomiting/ laxatives/ diuretics/ diet pills/ exercise 44. Y N
45. Do you regularly exercise outside of your normal practice schedule? If yes, describe your activities. \_\_\_\_\_ 45. Y N
46. Have you ever wanted to weigh less? 46. Y N
47. Have you ever wanted to weigh more? 47. Y N
48. Do you think you might have an eating disorder? 48. Y N
49. Have you ever been diagnosed with an eating disorder? 49. Y N
50. Have you ever been treated for a stress fracture? 50. Y N  
If yes, how many have you had? \_\_\_\_  
What body part(s) was involved? \_\_\_\_\_  
When did it occur? \_\_\_\_\_  
How was the diagnosis made (x-ray, bone scan, MRI, CT)? \_\_\_\_\_
51. **FEMALES ONLY:** Have you ever had a menstrual period? 51. Y N  
If yes —  
\*How old were you when you had your first menstrual period? \_\_\_\_\_  
\*When was your last period? \_\_\_\_\_  
\*How long are your periods? \_\_\_\_\_  
\*How many periods have had in the past 12 months? \_\_\_\_\_ In the past 6 months? \_\_\_\_\_
52. Have you ever missed 3 or more consecutive months of your menstrual periods? 52. Y N  
If yes, how many consecutive months have you ever missed your period? \_\_\_\_\_
53. Does your menstrual cycle change with the intensity, frequency or duration of training? If yes, does it become Lighter/ Heavier/ Shorter/ Longer/ Disappear 53. Y N
54. Are you on birth control or hormones? If yes, were they prescribed for (circle one) irregular periods/ no periods/ painful periods/ birth control 54. Y N
55. When was your last pelvic examination? \_\_\_\_\_ 55. Y N
56. Have you ever been treated for anemia (low hemoglobin or iron)? 56. Y N
57. Is there any history of osteoporosis (thinning of the bones) in your family? 57. Y N

Explain yes answers here: \_\_\_\_\_

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**I hereby state that, to the best of my knowledge, my answers to the above questions are correct and accurate.**

**Athlete's/Land Sea Participants Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Guardian if Under 18** \_\_\_\_\_

# Physical Examination

Date: \_\_\_\_\_

Name \_\_\_\_\_ Sport \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Vision R \_\_\_\_\_ L \_\_\_\_\_ Corrected Y N Participating in Land Sea: Y N

REGION	NORMAL	ABNORMAL	COMMENTS
Appearance			
Lymph Nodes			
Eyes/ Ears/ Nose/ Throat			
Heart/Pulses			
Lungs			
Abdomen			
Hernia			
Skin			
Neck			
Back/Hip/Thigh			
Shoulders/ Arms			
Wrists/ Hands			
Knees			
Legs			
Ankles			
Feet			
Nervous (if indicated)			
Other			

Cleared for Sport Participation: Y N Cleared for Land Sea: Y N

Cleared Pending Further Study: \_\_\_\_\_

Cleared with Limitations \_\_\_\_\_

Comments/ Recommendations \_\_\_\_\_

Physician Name (print) \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_