



La Sierra University
Department of Intercollegiate Athletics
Riverside, CA 92515

PRE-PARTICIPATION HEALTH HISTORY

Date ____/____/____

Sport _____

Men's or Women's

Name _____

Date of Birth _____

(Local) Address _____

Social Security # _____

City/State/Zip _____

Insurance Co. _____

Home Phone # _____

HMO or PPO _____

Cell Phone Number _____

Insurance Address _____

LSU ID # _____

City/State/Zip _____

Ins Co. Policy Number _____

Insurance Co. Phone Number _____

In case of emergency, notify (LOCALLY):

Parent's Name (Insurance Sponsor) _____

Name _____

Address _____

City _____

City/State _____

Relationship _____

Phone – home _____

Home phone _____ Phone-cell _____

Phone – work & cell _____

Parent SS# _____

Date of last physical exam by a doctor _____

Date of last tetanus booster _____

- a. Have you been under a doctor's care in the past 12 months? YES () NO ()
- b. Have you been in the hospital in the past 12 months? () ()
- c. Have you had any type of surgery? () ()
- d. Do you wish to talk to a doctor about a health problem or injury? () ()

- i. Have you ever had or now have: YES NO
- Concussion (head injury) () ()
- Skull fracture () ()
- Convulsion or epilepsy () ()
- Neck injury () ()
- Stinger, burner, pinched nerve () ()

Explain all "yes" answers. _____

Explain all "yes" answers. _____

- e. Has anyone in your immediate family ever had:
- Diabetes (high blood sugar) () ()
- Hives or rashes () ()
- Stroke () ()
- Heart Trouble () ()
- High blood pressure () ()
- High Cholesterol () ()
- Epilepsy () ()
- Sickle cell anemia (trait) () ()
- Osteoporosis () ()

- j. Have you had or do you now have:
- To wear glasses or contacts () ()
- Impaired vision in one eye () ()
- Temporary loss of vision () ()
- Hearing loss () ()
- Perforated eardrum () ()
- Recurrent ear infections () ()
- k. Have you had or do you now have:
- Broken nose () ()
- Sinus infections () ()
- Nose bleeds () ()
- Dental plate or dentures () ()
- Orthodontia (braces) () ()

For each "yes" answer, identify the family member, the condition, and the age. _____

Explain all "yes" answers. _____

- f. Has anyone in your family, under age 50, died suddenly? () ()

- l. Have you had or do you now have:
- Diabetes () ()
- Tendency to bruise easily () ()
- Anemia () ()
- Thyroid trouble () ()
- Mononucleosis () ()
- Hepatitis () ()
- Tuberculosis () ()
- Gonorrhea or Syphilis () ()

Explain. _____

Explain all "yes" answers. _____

- g. Have you ever had a problem with drugs or alcohol? () ()

Explain. _____

- h. Have you ever had a heat illness? () ()

Explain. _____

m. Have you had or do you now have:

	YES	NO
Hernia	()	()
Kidney problems	()	()
Loss of a kidney	()	()
Loss of function or absence of a testicle (men only)	()	()
Stomach or peptic ulcer	()	()
Migraine headaches	()	()

n. Have you had or do you now have:

Weight problems	()	()
Disordered eating	()	()
Dieting problems	()	()

Explain all "yes" answers. _____

r. Have you had or do you now have:

	YES	NO
High blood pressure	()	()
Heart trouble or murmur	()	()
Persistent cough	()	()
Tendency to faint	()	()
Dizziness/faintness with exercise	()	()
Chest pain/discomfort with exercise	()	()

s. Have you had or do you now have:

Recurrent rash	()	()
Fungus infection	()	()
Athlete's foot	()	()
Recurrent boils (skin infections)	()	()

Explain all "yes" answers. _____

o. Have you had or do you now have:

Hay fever	()	()
Exercised induced asthma	()	()
Asthma	()	()
Allergies to bites/stings	()	()
Do you need /use an Epi pen	()	()
Do you need /use an inhaler	()	()

p. Are you allergic to:

Penicillin	()	()
Other medications	()	()
Any food	()	()
Other substances	()	()

Explain all "yes" answers. _____

t. Have you ever had an electrocardiogram (EKG)? () ()
Explain. _____

u. Do you wish to discuss an emotional problem with the doctor? () ()

v. Do you have a loss of a paired organ () ()
Explain. _____

w. Have you ever been told to give up sports because of a health problem? () ()
Explain. _____

q. Do you:

Smoke	()	()
Take any medication regularly	()	()
Take any medication for emergency use	()	()

if YES, name of medication _____

x. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc)? () ()
Explain. _____

y. Do you take any vitamins? Please List.

z. Do you take any supplements or herbs? Please list.

WOMEN ATHLETES ONLY

Age at the onset of menstruation _____

Have you ever had or do you now have:

Amenorrhea (loss of menses)	yes	no	Dysmenorrhea (very painful menses, cramping)	yes	no
Oligomenorrhea (irregular menses)	yes	no	Endometriosis	yes	no

Do you currently use:

Birth control pills	yes	no	Implanted uterine device/Depo-Provera	yes	no
---------------------	-----	----	---------------------------------------	-----	----

Name/Brand of Birth control Pills _____

Date of last menstrual period _____

How Many Periods have you had in the last year? _____

Date of last women's health exam _____

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

Signature _____ Signature of Parent/Guardian _____ Date _____

FOR THE FOLLOWING QUESTIONS, BE AS SPECIFIC AS POSSIBLE. DETAIL **WHAT** HAPPENED, **WHEN** IT HAPPENED, **RIGHT OR LEFT**, CASTED OR IMMOBILIZED, HOW LONG, ANY REHABILITATION, DOCTOR'S NAME AND CITY.

- Yes No 1. Have you had a finger, hand or wrist injury? _____

- Yes No 2. Have you had a sprain, dislocation, fracture, or other injury to the forearm or elbow? _____

- Yes No 3. Have you had a shoulder dislocation, separation, or other injury? _____

- Yes No 4. Have you had an injury to your hip or pelvis area? _____

- Yes No 5. Have you had knee arthroscopy or surgery? What other injuries have you had to your knees? _____

- Yes No 6. Have you experienced a severe ankle sprain or injury to your foot or ankle? _____

- Yes No 7. Have you had an injury to your upper or lower back? _____

- Yes No 8. Do you experience pain in your back? Seldom _____ Occasionally _____ Frequently _____
- Yes No 9. Do you wear orthotics in your shoes? Why? Who prescribed them and when? _____

- Yes No 10. Have you had any problems with muscles strains or pulls? _____

- Yes No 11. Have you had any other significant injuries? _____

- Yes No 12. Have you had any other operations in the past five years? Explain in detail: _____

- Yes No 13. Are you currently on prescribed medication? Indicate drug, doctor, why it was prescribed and dosage. _____

- Yes No 14. Are you currently under the care of a physician? Give length of time and reason for care. _____

I HAVE READ AND ANSWERED ALL OF THE ABOVE QUESTIONS COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____

ATC Reviewed _____

05/10



Pre-participation Physical Evaluation

La Sierra University

PHYSICAL EXAMINATION

Name _____	Date of birth _____
Height _____ Weight _____ %Body fat (optional) _____	Pulse _____ BP ____/____ (____/____, ____/____)
Vision: R 20/____ L 20/____ Corrected: Y N Pupils: Equal ____ Unequal ____ PPD Date: given _____ read: _____ result: _____	

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
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			

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print/type) _____ Date _____

Address _____ City _____ State _____

Phone _____

Signature of physician _____ MD or DO _____

Immunizations:

	Date of Vaccination			
Hepatitis B	1 st Dose _____	2 nd Dose _____	3 rd Dose _____	
Measles- Mumps Rubella	1 st Dose _____	2 nd Dose _____		
Tetanus-Diphtheria-Pertussis (within 10 years)	_____			
Meningococcal Vaccination (Recommended)	_____			