

# UTICA PARK CLINIC: PPE H&P

**Attachment A**

<b>HISTORY</b>		Date of examination _____	
Name _____	Sex M/F	Age _____	DOB _____
Activities(s) _____		Year 1 2 3 4 5	
Social Security Number _____			

**Circle questions to which you don't know the answer. Explain "Yes" answers below.**

	Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe viral infection (for example, <i>myocarditis</i> or <i>mononucleosis</i> ) within the past month?	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you cough, wheeze or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotic, retainer on your teeth or hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, check appropriate box and explain below.</i>		
<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Thigh
<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Knee
<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hip
<input type="checkbox"/> Shin/calf	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand
<input type="checkbox"/> Ankle	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger
<input type="checkbox"/> Foot	<input type="checkbox"/> Upper arm	
13. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
15. What are the dates of your most recent immunizations (shots) for:		
Tetanus? _____	Measles? _____	Hepatitis B? _____
		Chickenpox? _____

**Females Only**

16. When was your first menstrual period? \_\_\_\_\_ When was your most recent menstrual period? \_\_\_\_\_  
 How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_  
 How many periods have you had in the past year? \_\_\_\_\_

**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 complete and correct.**

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# Utica Park Clinic Pre-participation History & Physical Evaluation

## PHYSICAL EXAMINATION

Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y N Pupils Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	Normal	Abnormal findings
<b>MEDICAL</b>		
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
<b>MUSCULOSKELETAL</b>		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

\*Station-based examination only

## CLEARANCE

Cleared       Cleared after completing evaluation/rehabilitation for

\_\_\_\_\_  
 \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Recommendations:

\_\_\_\_\_  
 \_\_\_\_\_

Name of physician \_\_\_\_\_  
 (Print or type)

Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_

M.D./D.O.