San Jose City College
Student Health Services
Pre-Participation Medical Evaluation Form

Today’s Date: ______________________

Name: ____________________________ Sex: _______ DOB: __________ Age: __________

Sport: ____________________________ Coach: ____________________________

Personal History

1. Have you had a medical illness or injury since your last check up or sports physical? Yes No
2. Do you have an ongoing chronic illness? .........Yes No
3. Have you ever been hospitalized overnight? ......Yes No
4. Have you ever had surgery? .........................Yes No
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? Yes No
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? ........................................Yes No
7. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? ...Yes No
8. Have you ever had a rash or hives develop during or after exercise? .........................Yes No
9. Have you ever passed out during or after exercise? ........................................Yes No
10. Have you ever had chest pain during or after exercise? .................................Yes No
11. Do you get tired more quickly than your friends do during exercise? .....................Yes No
12. Have you had high blood pressure or high cholesterol? .................................Yes No
13. Have you ever had racing of your heart or skipped heartbeats? .............................Yes No
14. Has any family member or relative died of heart problems or sudden death before age 50? Yes No
15. Have you had severe viral infection (for example, myocarditis or mononucleosis) within the last month? ........................................Yes No
16. Has a physician ever denied or restricted your participation in sports for any heart problems? ..Yes No
17. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? ........................................Yes No
18. Have you ever had a head injury or concussion? Yes No
19. Have you ever been knocked out, become unconscious or lost your memory? ..........Yes No
20. Have you ever had a seizure? .........................Yes No
21. Do you have frequent or severe headaches? ......Yes No
22. Have you ever had numbness or tingling in your arms, hands, legs, or feet? .........Yes No
23. Have you ever had a stinger, burner or pinched nerve? ........................................Yes No
24. Have you ever became ill from exercising in the heat? ........................................Yes No
25. Do you cough, wheeze, or have trouble breathing during or after activity? ............Yes No
26. Do you have asthma? .................................Yes No
27. Do you have seasonal allergies that require medical treatment? ..........................Yes No
28. 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 orthotics, retainer on your teeth or hearing aid)? ........Yes No
29. Have you had any problems with your eyes or vision? ........................................Yes No
30. Do you wear glasses, contacts, or protective eyewear? ........................................Yes No
31. Have you ever had a sprain, strain, or swelling after injury? .................................Yes No
32. Have you broken or fractured any bones or dislocated any joints? .......................Yes No
33. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?..Yes No
34. Do you want to weight more or less than you do now? ........................................Yes No
35. Do you lose weight regularly to meet weight requirements for your sport? ......................Yes No
36. Do you feel stressed? .................................Yes No
37. Record the dates of your most recent immunizations (shots) for:
   - Tetanus: __________  Measles: __________
   - Hepatitis B: __________ Chickenpox: __________

FEMALES ONLY

38. When was your first menstrual cycle? __________
39. When was your most recent menstrual period? __________
40. How much time do you usually have from the start of one period to the start of another? __________

Please explain all “yes’ answers here:

__________________________________________________________________________________________

__________________________________________________________________________________________

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

Signature: ____________________________ Date: ____________
Physical Examination

Student’s Name __________________________ DOB: ___________ ID#: ___________

Height: ______ Weight: _______ Temp: _______ BP: _______ P: _______ HGB: _______ O2 Sat: ______

Urine Protein: _______ Glucose: _______

Vision R: 20/_____ L: 20/_____ Corrected: Yes No Pupils: Equal ____ Unequal ____

MEDICAL Normal Abnormal Findings

<table>
<thead>
<tr>
<th>Eyes/Ears/Nose</th>
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<tbody>
<tr>
<td>Throat/Mouth</td>
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<tr>
<td>Lymph Nodes</td>
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<td>Heart</td>
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<td>Breast</td>
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<td>Lungs</td>
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<td>Abdomen</td>
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<td>Hernia</td>
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<td>Genitalia (males only)</td>
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<td>Skin</td>
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<td>Sensory</td>
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MUSCULOSKELETAL Normal Abnormal Findings

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<thead>
<tr>
<th>Neck</th>
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<tbody>
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<td>Back</td>
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<tr>
<td>Shoulder/Arm</td>
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<td>Elbow/Forearm</td>
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<td>Wrist/Hand</td>
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<td>Hip/Thigh</td>
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<td>Knee</td>
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<td>Leg/Ankle</td>
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<td>Foot</td>
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<td>Reflexes</td>
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Recommendations: __________________________________________________________

____________________________________________________________________________

Clearance: □ Cleared without limitations
□ Cleared after completing evaluation/rehabilitation for: __________________________

____________________________________________________________________________

□ Not cleared for: ___________________________ Reason: __________________________

____________________________________________________________________________

I certify that I have, on this date, examined this student and that, on the basis of the examination and the student’s medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (not exceptions above).

Physicians Name: __________________________ Signature: __________________________ Date: _______