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

Today's Date: _____

I authorize the release of a copy of my physical examination to the trainer of the SJCC Athletic Department

Signature: _____

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

    Head _____ Elbow _____ Hip _____
    Neck _____ Forearm _____ Thigh _____
    Back _____ Wrist _____ Knee _____
    Chest _____ Hand _____ Shin/Calf _____
    Shoulder _____ Finger _____ Ankle _____
    Upper Arm _____ Foot _____
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: _____

San Jose City College Student Health Services
2100 Moorpark Avenue, SC-109
San Jose, CA 95128
Office: 408-288-3724 Fax: 408-297-4865

Physical Examination

Student's Name _____ DOB: _____ ID#: _____

Height: _____ Weight: _____ Temp: _____ BP: _____ P: _____ HGB: _____ O^2 Sat: _____

Urine Protein: _____ Glucose: _____

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

MEDICAL	Normal	Abnormal Findings
Eyes/Ears/Nose		
Throat/Mouth		
Lymph Nodes		
Heart		
Breast		
Lungs		
Abdomen		
Hernia		
Genitalia (males only)		
Skin		
Sensory		

MUSCULOSKELETAL	Normal	Abnormal Findings
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		
Reflexes		

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: _____