WESTERN NEW ENGLAND UNIVERSITY | WNE
1215 Wilbraham Road, Spring ield, MA 01119-2684
TEL: 413-782-1211 • FAX: 413-796-2255
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HEALTH SERVICES

Athletic Preparticipation Evaluation

This form is for use by returning athletes only

and cannot be completed prior to 6 months before August 27

Name of Student Athlete:_____ Sex:_____ Age:_____ Date of Birth:_____

Sport/s:_____

Athlete explain all "yes" answers in the space provided

	Yes	No
I. Have you had a medical illness or injury since your last check up or sport's physical?	❑	❑
Do you have an ongoing or chronic illness?	❑	❑
2. Have you ever been hospitalized overnight?	❑	❑
Have you ever had surgery?	❑	❑
3. Are you currently taking any prescription or over-the-counter medication or using an inhaler?	❑	❑
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	❑	❑
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	❑	❑
Have you ever had a rash or hives develop during or after exercise?	❑	❑
5. Have you ever passed out during or after exercise?	❑	❑
Have you ever been dizzy during or after exercise?	❑	❑
Have you ever had chest pain during or after exercise?	❑	❑
Do you get tired more quickly than your friends do during exercise?	❑	❑
Have you ever had racing of your heart or skipped heartbeats?	❑	❑
Have you ever had high blood pressure or high cholesterol?	❑	❑
Have you ever been told you have a heart murmur?	❑	❑
Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
Have you had a severe viral infection like myocarditis or mononucleosis within the last month?	❑	❑
Has a health care provider ever denied or restricted your participation in sports for any heart problems?	❑	❑
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	❑	❑
7. Have you ever had a head injury or concussion?	❑	❑
Have you ever been knocked out, become unconscious, or lost your memory?	❑	❑
Do you have frequent or severe headaches?	❑	❑
Have you ever had numbness or tingling in your arms, legs or feet?	❑	❑
Have you ever had a burner, stinger or pinched nerve?	❑	❑
8. Have you ever become ill from exercising in the heat?	❑	❑
9. Do you cough, wheeze or have trouble breathing?	❑	❑
Do you have asthma?	❑	❑
10. Do you use any special protective or corrective equipment that aren't usually for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth or hearing aid)?	❑	❑
11. Have you had any problems with your eyes or vision?	❑	❑
12. Have you ever had a sprain, strain or swelling after injury?	❑	❑
Have you broken or fractured any bones or dislocated any joints?	❑	❑
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	❑	❑
(If yes check appropriate box and explain below)		
❑ Head ❑ Elbow ❑ Hip ❑ Neck ❑ Forearm ❑ Thigh ❑ Back		
❑ Hand ❑ Wrist ❑ Knee ❑ Chest ❑ Finger ❑ Ankle ❑ Foot		
❑ Shin or calf ❑ Upper Arm ❑ Shoulder		
13. Do you want to weigh more or less than you do now?	❑	❑
Do you regularly lose weight to meet weight requirements for your sport?	❑	❑
Have you ever been or are you presently anorexic or bulimic?	❑	❑
14. Do you feel stressed out?	❑	❑

FEMALES ONLY

15. When was your first menstrual period? _____

When was your most recent menstrual period? _____

How many periods have you had in the last year?_____

Explain all "yes" answers here and continue on reverse

_____

_____

_____

_____

_____

_____

_____

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

Signature of Athlete_____

Date_____

The remainder of this form to be completed by the health care provider

After reviewing this health history form with the patient/athlete I have determined that he/she is ...

❑ Cleared ❑ Cleared with Recommendations (reason and comments on reverse) ❑ Not Cleared (reason and comments on reverse)

MD/DO/NP/PA (print or type name) _____ Signature _____

Address_____Telephone_____Date of Evaluation _____

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HEALTH SERVICES

Athletic Preparticipation Physical Examination

This form is for use by returning student athletes

(Not to be used by freshman or transfer student athletes)

Name of Student Athlete:_____ Sex:_____ Age:_____ Date of Birth:_____

Sport/s:_____

Height :_____ Weight:_____ BP:_____ Pulse:_____ Vision R 20/:_____ L 20/:_____ Corrected: ❑ Yes ❑ No

	Normal	Abnormal Findings
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		

❑ **Cleared** ❑ **Cleared with Recommendations** (reason and comments on reverse) ❑ **Not Cleared** (reason and comments on reverse)

MD/DO/NP/PA (print or type name): _____

Signature: _____

Address: _____

Telephone:_____ Date of Evaluation:_____