University of Bridgeport

Intercollegiate Athletic Department

Pre-Participation Physical Examination Form

PART A: STUDENT-ATHLETE HEALTH HISTORY QUESTIONNAIRE

Today's Date:_____

Student Athlete's Name: _____ Sex: M F (circle one) Date of Birth: _____/____/_____

UB ID #: _____ Email:_____ Sport (s): _____

Home Address: _____ Home Phone: (_____) _____

School Address: _____ Cell Phone: (_____)_____

MEDICAL HISTORY

Answer the following medical history questions. Please circle "YES" or "NO".
Please explain all "YES" answers on the next page.

Do you have Asthma or wheezing?	YES NO	Have you ever had a sexually transmitted disease?	YES NO
Do you have Exercise Related Asthma?	YES NO	Have you ever had malaria?	YES NO
Do you have chronic cough?	YES NO	Have you ever had whooping cough?	YES NO
Have you ever had bronchitis?	YES NO	Have you ever had tuberculosis (TB) or a positive skin test?	YES NO
Have you ever had pneumonia?	YES NO	Have you ever had meningitis?	YES NO
Have you ever had recurrent pneumonia?	YES NO	Have you ever had paralysis/polio?	YES NO
Have you ever had pleurisy?	YES NO	Have you had a recent viral infection?	YES NO
Have you ever had shortness of breath?	YES NO	Is vision in one or both eyes 20/200 or worse?	YES NO
Do you smoke? If yes, how much? _____	YES NO	Do you wear glasses or contacts during play?	YES NO
Have you ever had dizzy spells or fainted?	YES NO	Do you have color blindness?	YES NO
Do you or have you ever had hypertension?	YES NO	Have you had an eye injury or retinal detachment disease?	YES NO
Have you ever had a heart murmur?	YES NO	Have you ever had double vision?	YES NO
Have you ever had an irregular heart beat?	YES NO	Do you have deafness or hard of hearing in one or both ears?	YES NO
Have you ever had a racing heart of felt your heart skip a beat?	YES NO	Do you wear a hearing aid?	YES NO
Do you have high cholesterol?	YES NO	Have you ever had a perforated eardrum?	YES NO
Do you have heart palpitations?	YES NO	Have you had repeated ear infections?	YES NO
Has a physician ever denied you participation in sports for a cardiac reason?	YES NO	Do you have ventilation tubes or a perforated eardrum?	YES NO
Has any member of your family had a sudden death?	YES NO	Have you had a fractured nose or deviated septum?	YES NO
Has any member of your family had a heart attack under the age of 50?	YES NO	Do you have frequent sore throats?	YES NO

Athlete name: MEDICAL HISTORY (CONT.)

Do you have a heart problem or chest pains?	YES NO	Have you had your tonsils/adenoids removed?	YES NO
Have you passed out while exercising?	YES NO	Have you had sinus trouble?	YES NO
Do you have to stop when running ½ mile?	YES NO	Do you have dental braces or false teeth?	YES NO
Have you ever had chest pain during or after exercise?	YES NO	Have you ever had anorexia nervosa?	YES NO
Do you have frequent headaches or migraines?	YES NO	Have you ever had bulimia?	YES NO
Have you ever had a severe head injury?	YES NO	Have you ever had obesity?	YES NO
Have you ever had a concussion? If yes, did you lose consciousness? Y N	YES NO	Have you ever had a sudden weight change?	YES NO
Have you become weak or lost consciousness after heat exposure?	YES NO	Do you need a special diet?	YES NO
Have you ever had mononucleosis?	YES NO	Have you had recurrent anxiety?	YES NO
Have you ever had chicken pox?	YES NO	Have you had excessive nervousness?	YES NO
Have you ever had rheumatic or scarlet fever?	YES NO	Have you had insomnia?	YES NO
Have you had recurrent depression?	YES NO	Have you ever had a pinched nerve?	YES NO
Have you had a neuromuscular disorder?	YES NO	Do you have low back pain?	YES NO
Have you ever had a seizure or convulsions?	YES NO	Have you ever had a disc problem?	YES NO
Do you bleed easily or take a long time to stop bleeding?	YES NO	Have you ever had a hip problem?	YES NO
Do you have sickle cell trait or disease?	YES NO UNKN	Have you ever had a knee sprain?	YES NO
Do you have acne?	YES NO	Have you ever had “water” on your knee?	YES NO
Do you have a skin problem or rash including hives?	YES NO	Have you ever had pain beneath your kneecaps?	YES NO
Do you have other skin diseases?	YES NO	Have you ever had to brace your knee?	YES NO
Have you had chronic abdominal pain?	YES NO	Have you ever had “jumper’s knee” or patellar tendonitis?	YES NO
Have you had ulcers?	YES NO	Have you ever had shin splints?	YES NO
Have you had colitis/ileitis?	YES NO	Have you had any foot or ankle problems, including sprains or recurrent pain and swelling, Achilles tendonitis, or a sprained arch?	YES NO
Have you had chronic/recurrent diarrhea?	YES NO	Have you ever had a shoulder dislocation, rotator cuff strain, or recurrent shoulder pain?	YES NO
Have you had irritable bowel syndrome?	YES NO	Have you had wrist or elbow problems, including sprains, recurrent swelling or pain?	YES NO
Have you had gallstones?	YES NO	Have you ever had finger problems, including sprains, dislocations, recurrent swelling or pain?	YES NO
Have you had hepatitis or jaundice?	YES NO	Have you ever had any muscle pulls or strains?	YES NO
Have you had an appendectomy?	YES NO	Have you ever had a fracture? If yes, which bone?_____	YES NO
Have you had hemorrhoid troubles?	YES NO	Have you ever had a dislocation? If yes, which joint? _____	YES NO
Do you have liver disease?	YES NO	Have you ever had any operations?	YES NO
Do you have frequent urination?	YES NO	Have you ever had arthritis?	YES NO

Athlete name: MEDICAL HISTORY (CONT.)

Do you have blood in the urine?	YES NO	Have you ever had a serious injury/accident?	YES NO
Do you have recurrent urinary infections?	YES NO	Have you ever had an emotional problem/treatment?	YES NO
Do you have a kidney infection?	YES NO	Do you currently or have you recently used any drugs (i.e. anabolic steroids, cocaine, marijuana)?	YES NO
Have you ever had a kidney stone?	YES NO	Have you ever been hospitalized?	YES NO
Do you have diabetes?	YES NO	Do you have an undescended or absent testicle?	YES NO
Have you ever ruptured your spleen?	YES NO	Have you ever had a malignant disease?	YES NO
Have you ever had a serious illness?	YES NO	**FOR FEMALE PARTICIPANTS (only):**	
Have you ever had loss of an eye, kidney, or testicle?	YES NO	Do you currently have problems with menstrual irregularity?	YES NO
Have you ever had thyroid problems?	YES NO	Do you have disabling cramps with your period?	YES NO
Have you had a neck or spine injury? If so, year _____	YES NO	When was your last period?	___/__/____

Explanation of "YES" answers with dates:

Part B: PHYSICIAN'S PHYSICAL EXAM

Athlete Name:_____

FINDINGS OF PHYSICAL EVALUATION

Height: _____in **Weight**: _____lbs **Blood Pressure:** _____/_____ **Pulse:** _____bpm.

Vision: R 20/_____ L 20/ _____ **Corrected**: Y / N **Contacts:** Y / N **Glasses**: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head / Neck	YES	
Eyes / Sclera / Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose / Mouth / Throat	YES	
Lymph Glands	YES	

Cardiovascular

Heart Rate	YES				
Rhythm	YES				
Murmur	ABSENT				
If murmur present		**Standing makes it:**	Louder	Softer	No Change
		Squatting makes it:	Louder	Softer	No Change
		Valsalva makes it:	Louder	Softer	No Change
Femoral Pulses	YES				
Evidence of Marfan's Syndrome	ABSENT				
Lungs: Auscultation/Percussion	YES				
Chest Contour	YES				
Skin	YES				
Abdomen (liver, spleen, masses)	YES				
Assessment of physical maturation or Tanner Scale	YES				
Testicular Exam (Males Only)	YES				
Hernia	ABSENT				

Orthopedic

Neck / Back /Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	

Athlete Name:_____

Allergies (Medication / Food / Other):

_____
_____
_____

Medications currently prescribed, with dose and frequency:

_____
_____
_____
_____

Additional observations:

_____
_____
_____
_____

General Recommendations:

_____
_____
_____
_____

ATHLETIC PARTICIPATION CLEARANCES: (**Please Initial** the appropriate clearance level below)

A._____ Student is **Cleared** for participation in all sports without restriction.

B. _____Student is **Withheld** clearance for participation in any sport until evaluation / treatment of:

_____
_____

C. _____Student is cleared for participation in limited types of sports which exclude the following types of sports contact:
(CHECK ALL THAT APPLY)

___ CONTACT / COLLISION
___ LIMITED CONTACT
___ NON-CONTACT / STRENUOUS
___ NON-CONTACT / NON-STRENUOUS

Due to: _____

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician's/Provider's Stamp:

(Circle one)
Primary Care Provider
School Physician Provider

License Type: MD / DO
LPN / PA

PHYSICIAN'S / PROVIDER'S SIGNATURE: _____ Date: _____

Name: _____ Phone: _____ Fax: _____
(Print Physician's Name)
Address: _____ City/State/Zip:_____

UB DC SIGNATURE (IF APPLICABLE): _____ Date: _____

Name: _____ Phone: _____ Fax: _____
(Print Physician's Name)

UB TEAM PHYSICIAN REVIEWED

Name *(print)* _____

SIGNATURE: _____ Review Date: _____

NAME:_____ **DOB:**_____ **UB ID#:**_____

PART C - TO THE PHYSICIAN: THE FOLLOWING IMMUNIZATIONS ARE MANDATORY BY CONNECTICUT STATE LAW PRIOR TO REGISTRATION AND TO RESIDE IN ON-CAMPUS HOUSING.
PLEASE ATTACH LAB SLIP IF ANTIBODY TITRE IS BEING USED TO COMPLETE ANY OF THESE SECTIONS.

M.M.R. (Measles, Mumps, Rubella)	**1st Immunization Date:** ___/___/____ (mo) (day) (yr) **2nd Immunization Date:** ___/___/____ (mo) (day) (yr)
Varicella (Chickenpox) *TWO VARICELLA VACCINES ARE REQUIRED* *BOTH VACCINES MUST BE LISTED* * NOT required for students born in the United States before 1980*	**1st Immunization Date:** ___/___/____ (mo) (day) (yr) **2nd Immunization Date:** ___/___/____ (mo) (day) (yr) **OR** **CONFIRMED CASE OF DISEASE** by Physician or Public Health Director in student's present of previous town of residence. **Date:** ___/___/____ (mo) (day) (yr)
Meningitis *Required for ALL students who reside in on-campus housing after 2005*	**Immunization Date:** ___/___/____ (mo) (day) (yr)
**** PPD REQUIRED WITHIN 6 MONTHS OF ADMISSION INTO THE UNIVERSITY ****	
Tuberculin/PPD *History of having BCG Vaccine is not considered a contraindication*	Date Given:___/___/____ (mo) (day) (yr) Date Read: ___/___/____ (mo) (day) (yr) Results:_____mm History of PPD: Y / N Date:____/____/_____

ONLY if positive for PPD history - MANADATORY INFORMATION NEEDED

1. Prophylactic Treatment Dates: ____/____/_____ to ____/____/_____ **OR** Refused Treatment/ Prophylaxis (yes)_____
2. Chest X-Ray required if PPD not done and skin test is positive:
   Chest X-Ray Date:_____/_____/_____ Result:_____

Tetanus: Immunization Date: ____/____/_____
Other: _____ _____ _____

****STUDENT AUTHORIZATION FOR TREATMENT AT UB HEALTH SERVICES****

I hereby authorize the University of Bridgeport Student Health Services to provide medical treatment and services as they deem appropriate. This authorization will remain in effect as long as I am a registered student at the University of Bridgeport.

Student Signature:_____Date:_____

Signature of Parent or Guardian (if under the age of 18):_____Date:_____

Information on this page is confidential. It is for the use of health professionals; it will not be released without the student's written consent and will not affect admission status.

Recommendations:_____

Physician's Name (Print):_____ Telephone:_____
Address:_____

Physician's Signature:_____ **Date of Examination**: _____/_____/_____

- **STUDENTS WILL BE RESPONSIBLE FOR OBTAINING THESE VACCINES FROM AN OUTSIDE PROVIDER IF NECESSARY. DUE TO THE HIGH COST OF THESE VACCINES, PLEASE DISCUSS THESE REQUIREMENTS WITH YOUR PRIMARY CARE PROVIDER OR YOUR LOCAL HEALTH DEPARTMENT.**