

RUTGERS Preparticipation Physical

Academic Year: Fr. So. Jr. Sr.				Rutgers I.D.#		
Last Name:		First :		Sex:	Age:	Date of Birth:
Sport(s):		SS#:		Cell:	Email:	
Home Address:		City:		State:	Zip:	(H) Ph:
Personal Physician's Name & phone:						
In case of an emergency contact (name):				Relationship:		
Ph. (H):		Ph. (W):		Cell (Ph):		

Explain "YES" answers on back.			
		Yes	No
1	Has a doctor ever denied or restricted your participation in sports for any reason?	Y	N
2a	Have you ever been hospitalized overnight?	Y	N
2b	Have you ever had surgery?	Y	N
3a	Are you currently taking any prescription or non-prescription (over-the-counter) medications, pills or using an inhaler?	Y	N
3b	Do you have any allergies to medicines, pollens, foods or stinging insects?	Y	N
4a	Have you ever had discomfort, pain or pressure in your chest during or after exercise?	Y	N
4b	Have you ever passed out during or after exercise?	Y	N
4c	Have you ever been dizzy during or after exercise?	Y	N
5a	Does your heart race or skip beats during exercise?	Y	N
5b	Has a doctor ever told you that you have (check all that apply) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection	Y	N
5c	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	Y	N
6a	Has anyone in your family died for no apparent reason?	Y	N
6b	Does anyone in your family have a heart problem?	Y	N
6c	Has any family member or relative died of heart problems or of sudden death before age 50?	Y	N
6c	Does anyone in your family have Marfan syndrome?	Y	N
7	Do you have an ongoing medical condition (diabetes or asthma)?	Y	N
8a	Has a doctor ever told you that you have asthma or allergies?	Y	N
8b	Do you cough, wheeze, or have difficulty breathing during or after exercise?	Y	N
8c	Is there anyone in your family who has asthma?	Y	N
8d	Have you ever used an inhaler or taken asthma medicine?	Y	N
9	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	Y	N
10	Have you had mononucleosis (mono) within the last month?	Y	N
11a	Do you have any rashes, pressure sores, or other skin problems?	Y	N
11b	Have you ever had a herpes skin infection?	Y	N
12a	Have you ever had a head injury or concussion?	Y	N
12b	Have you been hit in the head, confused or lost your memory?	Y	N
12c	Have you ever had a seizure?	Y	N
12d	Do you have headaches with exercise?	Y	N
12e	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Y	N
12f	Have you ever been unable to move your arms or legs after being hit or falling?	Y	N
13	When exercising in the heat, do you have severe muscle cramps or become ill?	Y	N

Explain "YES" answers on back																							
		Yes	No																				
14	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Y	N																				
15a	Have you had any problems with your eyes or vision?	Y	N																				
15b	Do you wear glasses, contacts or protective eyewear such as goggles or a face shield?	Y	N																				
16a	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	Y	N																				
16b	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	Y	N																				
16c	Have you ever had a sprain, strain, or swelling after injury?	Y	N																				
16d	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: (If yes, circle body part and explain on back)	Y	N																				
	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Head</td> <td style="border: none;">Neck</td> <td style="border: none;">Chest</td> <td style="border: none;">Shoulder</td> <td style="border: none;">Upper Arm</td> </tr> <tr> <td style="border: none;">Elbow</td> <td style="border: none;">Forearm</td> <td style="border: none;">Wrist</td> <td style="border: none;">Hand</td> <td style="border: none;">Finger</td> </tr> <tr> <td style="border: none;">Back</td> <td style="border: none;">Hip</td> <td style="border: none;">Thigh</td> <td style="border: none;">Knee</td> <td style="border: none;">Shin/Calf</td> </tr> <tr> <td style="border: none;">Ankle</td> <td style="border: none;">Foot</td> <td colspan="3" style="border: none;"></td> </tr> </table>	Head	Neck	Chest	Shoulder	Upper Arm	Elbow	Forearm	Wrist	Hand	Finger	Back	Hip	Thigh	Knee	Shin/Calf	Ankle	Foot					
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Elbow	Forearm	Wrist	Hand	Finger																			
Back	Hip	Thigh	Knee	Shin/Calf																			
Ankle	Foot																						
16e	Have you ever had a stress fracture?	Y	N																				
16f	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Y	N																				
16g	Do you regularly use a brace or assistive device?	Y	N																				
17a	Are you unhappy with your weight?	Y	N																				
17b	Are you trying to gain or lose weight?	Y	N																				
17c	Has anyone recommended you change your weight or eating habits?	Y	N																				
17d	Do you limit or carefully control what you eat?	Y	N																				
18a	Do you feel stressed out or under a lot of pressure?	Y	N																				
18b	Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	Y	N																				
19a	Have you ever tried cigarette smoking, even 1 or 2 puffs?	Y	N																				
19b	Do you currently smoke?	Y	N																				
19c	In the past 30 days, did you chew tobacco, snuff, or dip?	Y	N																				
20	In the past 30 days, have you had a drink of alcohol?	Y	N																				
21a	Have you ever taken steroid pills or shots without a doctor's prescription?	Y	N																				
21b	Have you ever taken any supplements to help you gain or lose weight or improve your performance?	Y	N																				
22	Do you have any concerns that you would like to discuss with a doctor?	Y	N																				
FEMALES ONLY																							
23	When was your first menstrual period? _____																						
24	How many periods have you had in the last 12 months? _____																						

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

Date: / /

Signature of athlete: