HARTWICK COLLEGE

History Form | Intercollegiate Athletes Only

Date of exam must be kept within 12 calendar months to maintain eligibility.

Student Name _____ *Date of Exam* _____/_____/_____

Sport(s) _____ *DOB* _____/_____/_____ *Gender* _____

Form must be completed and returned to Perrella Health Center at least 2 weeks prior to sports participation. NO EXCEPTIONS.
Questions? Call Perrella Wellness Center at: 607-431-4120 | Fax: 607-431-4124 | email: healthcenter@hartwick.edu

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:	☐	☐
3. Have you ever spent the night in the hospital?	☐	☐
4. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
7. Does your heart ever race or skip beats (irregular beats) during exercise?	☐	☐
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other: _____	☐	☐
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	☐	☐
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	☐	☐
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	☐	☐
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐	☐
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	☐	☐
18. Have you ever had any broken or fractured bones or dislocated joints?	☐	☐
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	☐	☐
20. Have you ever had a stress fracture?	☐	☐
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	☐	☐
22. Do you regularly use a brace, orthotics, or other assistive device?	☐	☐
23. Do you have a bone, muscle, or joint injury that bothers you?	☐	☐

OTHER MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
27. Have you ever used an inhaler or taken asthma medicine?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
30. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
31. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
32. Do you have any rashes, pressure sores, or other skin problems? (i.e. MRSA)	☐	☐
34. Have you ever had a head injury or concussion?	☐	☐
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	☐	☐
36. Do you have a history of seizure disorder?	☐	☐
37. Do you have headaches with exercise?	☐	☐
40. Have you ever become ill while exercising in the heat?	☐	☐
41. Do you get frequent muscle cramps when exercising?	☐	☐
42. Do you or someone in your family have sickle cell trait or disease?	☐	☐
43. Have you had any problems with your eyes or vision?	☐	☐
44. Have you had any eye injuries?	☐	☐
45. Do you wear glasses or contact lenses?	☐	☐
48. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
49. Are you on a special diet or do you avoid certain types of foods?	☐	☐
50. Have you ever had an eating disorder?	☐	☐
FEMALES ONLY		
54. How many periods have you had in the last 12 months? _____		
MEDICINES AND ALLERGIES	**Yes**	**No**
Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.		
_____		
_____		
_____		
_____		
_____		
55. Do you have any allergies?	☐	☐
If yes, please identify specific allergy below. ☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects		

EXPLANATION AND DATES FOR ALL "YES" ANSWERS HERE _____

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct. In signing this document, I give permission for my sports history and physical forms, updates regarding injury or illness, and information regarding my medical clearance for athletic participation may be shared with my coach, the athletic training staff, and the athletic administrative staff as deemed appropriate by the Perrella medical staff.

_____ _____/_____/_____
Signature of athlete **Date**

_____ _____/_____/_____
Signature of parent/guardian (if under 18) **Date**

HARTWICK COLLEGE

Physical Examination Form | Intercollegiate Athletes Only

Must be completed by health care provider. Date of exam must be kept within 12 calendar months to maintain eligibility.

_____ _____/_____/_____ _____/_____/_____

Student Name *Date of Birth* *Date of Exam*

Form must be completed and returned to Perrella Health Center at least 2 weeks prior to sports participation. NO EXCEPTIONS.

Questions? Call Perrella Wellness Center at:607-431-4120 | Fax: 607-431-4124 | email: healthcenter@hartwick.edu

EXAMINATION

Height Weight BP / (/) Pulse

Vision R 20/ L 20/ Corrected ☐ Yes ☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

a Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

b Consider GU exam if in private setting. Having third party present is recommended.

c Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

I have examined the above-named student, reviewed the History Form, and completed the preparticipation physical evaluation. This athlete is cleared to practice and participate in the sport(s) as outlined above without restriction **unless noted below**.

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared:
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

_____ _____/_____/_____

Name of healthcare provider (print or stamp) **Date**

_____ _____ _____

Address **Phone**

_____

Signature of healthcare provider