



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?	<input type="checkbox"/> <input type="checkbox"/>
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____	<input type="checkbox"/> <input type="checkbox"/>
3. Have you ever spent the night in the hospital?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you ever had surgery?	<input type="checkbox"/> <input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU	Yes/No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/> <input type="checkbox"/>
7. Does your heart ever race or skip beats (irregular beats) during exercise?	<input type="checkbox"/> <input type="checkbox"/>
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other: _____	<input type="checkbox"/> <input type="checkbox"/>
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	<input type="checkbox"/> <input type="checkbox"/>
10. Do you get lightheaded or feel more short of breath than expected during exercise?	<input type="checkbox"/> <input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes/No
11. 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)?	<input type="checkbox"/> <input type="checkbox"/>
12. 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?	<input type="checkbox"/> <input type="checkbox"/>
13. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	<input type="checkbox"/> <input type="checkbox"/>
14. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	<input type="checkbox"/> <input type="checkbox"/>

BONE AND JOINT QUESTIONS	Yes/No
15. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	<input type="checkbox"/> <input type="checkbox"/>
16. Have you ever had any broken or fractured bones or dislocated joints?	<input type="checkbox"/> <input type="checkbox"/>
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	<input type="checkbox"/> <input type="checkbox"/>
18. Have you ever had a stress fracture?	<input type="checkbox"/> <input type="checkbox"/>
19. 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)	<input type="checkbox"/> <input type="checkbox"/>
20. Do you regularly use a brace, orthotics, or other assistive device?	<input type="checkbox"/> <input type="checkbox"/>
21. Do you have a bone, muscle, or joint injury that bothers you?	<input type="checkbox"/> <input type="checkbox"/>

OTHER MEDICAL QUESTIONS	Yes/No
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>
23. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/> <input type="checkbox"/>
24. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/> <input type="checkbox"/>
25. Do you have groin pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/> <input type="checkbox"/>
26. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/> <input type="checkbox"/>
27. Do you have any rashes, pressure sores, or other skin problems? (i.e. MRSA)	<input type="checkbox"/> <input type="checkbox"/>
28. Have you ever had a head injury or concussion?	<input type="checkbox"/> <input type="checkbox"/>
29. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	<input type="checkbox"/> <input type="checkbox"/>
30. Do you have a history of seizure disorder?	<input type="checkbox"/> <input type="checkbox"/>
31. Do you have headaches with exercise?	<input type="checkbox"/> <input type="checkbox"/>
32. Have you ever become ill while exercising in the heat?	<input type="checkbox"/> <input type="checkbox"/>
33. Do you get frequent muscle cramps when exercising?	<input type="checkbox"/> <input type="checkbox"/>
34. Do you or someone in your family have sickle cell trait or disease?	<input type="checkbox"/> <input type="checkbox"/>
35. Have you had any problems with your eyes or vision?	<input type="checkbox"/> <input type="checkbox"/>
36. Have you had any eye injuries?	<input type="checkbox"/> <input type="checkbox"/>
37. Do you wear glasses or contact lenses?	<input type="checkbox"/> <input type="checkbox"/>
38. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/> <input type="checkbox"/>
39. Are you on a special diet or do you avoid certain types of foods?	<input type="checkbox"/> <input type="checkbox"/>
40. Have you ever had an eating disorder?	<input type="checkbox"/> <input type="checkbox"/>

FEMALES ONLY
41. 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. _____ _____ _____	

42. Do you have any allergies?	<input type="checkbox"/> <input type="checkbox"/>
If yes, please identify specific allergy below. <input type="checkbox"/> Medicines <input type="checkbox"/> Pollens <input type="checkbox"/> Food <input type="checkbox"/> Stinging Insects	

SARS-CoV-2 (COVID-19)	
43. Have you had COVID-19? Date of diagnosis: ____/____/____ Were you cleared for athletics post Covid 19?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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 ____/____/____



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. The initial exam must be completed within 6 months of first participation in athletics at Hartwick College.

Student Name _____ Date of Birth ____/____/____ Date of Exam ____/____/____

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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		

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?

MUSCULOSKELETAL

Neck		
Back		
Upper extremities		
Lower extremities		
Functional ● Duck-walk, single leg hop		

SARS-CoV-2 (COVID-19)

Has this athlete been diagnosed with COVID-19? Yes No If yes, date of infection: ____/____/____
List any post diagnosis athletic clearance performed, with date(s): _____

- 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 _____