

**Baylor University Spirit Squad**  
**Pre-participation Physical Evaluation**

**History**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Baylor ID# \_\_\_\_\_

State, Zip Code \_\_\_\_\_ Phone \_\_\_\_\_ Class \_\_\_\_\_

Explain "Yes" answers below:

	Yes	No
1. Have you ever been hospitalized? .....	0	0
Have you ever had surgery? .....	0	0
2. Are you presently taking any medication or pills? .....	0	0
3. Do you have any allergies (medicine, bees or other stinging insects)? .....	0	0
4. Have you ever passed out during or after exercise? .....	0	0
Have you ever been dizzy during or after exercise? .....	0	0
Have you ever had chest pain during or after exercise? .....	0	0
Do you tire more quickly than your friends during exercise? .....	0	0
Have you ever had high blood pressure? .....	0	0
Have you ever been told you have a heart murmur? .....	0	0
Have you ever had racing of your heart or skipped heartbeats? .....	0	0
Has anyone in your family died of heart problems or a sudden death before age 50? .....	0	0
5. Do you have any skin problems (itching, rashes, acne)? .....	0	0
6. Have you ever had a head injury? .....	0	0
Have you ever been knocked out or unconscious? .....	0	0
Have you ever had a seizure? .....	0	0
7. Have you ever had heat or muscle cramps? .....	0	0
Have you ever been dizzy or passed out in the heat? .....	0	0
8. Do you have trouble breathing or do you cough during or after activity? .....	0	0
9. Do you use any special equipment, braces, etc.)?.....	0	0
10. Have you had any problems with your eyes or vision? .....	0	0
Do you wear glasses or contacts or protective eye wear? .....	0	0
11. Have you ever had an eating disorder? .....	0	0
12. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?.....	0	0
13. Have you had a medical problem or injury since your last evaluation? .....	0	0
14. Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones or joints .....	0	0
<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist		
<input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot		
15. When was your first menstrual period? _____		
When was your last menstrual period? _____		
When was the longest time between your periods last year? _____		

Explain "Yes" Answers:

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

Signature of Athlete \_\_\_\_\_ Date \_\_\_\_\_

Pre-participation Physical Examination

COMPLETE	LIMITED	Height _____ Weight _____ BP _____ / _____ Pulse _____			
		Vision R20/ _____ L20/ _____ Corrected: Y N			
			Normal	Abnormal Findings	
		Cardiovascular			
		Pulses			
		Heart			
		Lungs			
	Skin				
	E.N.T.				
	Abdominal				
	Genitalia (males)				
	Musculoskeletal				
	Neck				
	Shoulder				
	Elbow				
	Wrist				
	Hand				
	Back				
	Knee				
	Ankle				
Foot					
Other					

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/ rehabilitation for: \_\_\_\_\_
- C. Not Cleared for:  Collision  Contact  Noncontact  
 Strenuous  Moderately strenuous  Non-strenuous

Due to: \_\_\_\_\_

Recommendation

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Physician \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Physician: \_\_\_\_\_, M.D. or D.O.