

NORTHERN MICHIGAN UNIVERSITY
ATHLETIC TRAINING
Pre-participation Evaluation

*Failure to report any previous or current injury/illness may result in your Financial Tender being null and void.

Name _____ Sex: M F Age _____ Date of Birth _____
 Last First MI

Sport _____ Today's Date _____

1. Have you ever been hospitalized? Yes No
 If so, when and why: _____

2. Have you ever had surgery? Yes No
 If so, when and why: _____

3. Do you have any allergies (medicines, bees, or other stinging insects?) Yes No
 If yes, explain: _____

4. Are you currently taking any medications? Yes No
 If yes, explain: _____

5. Have you ever passed out during or after exercise? Yes No
 Have you ever been dizzy during or after exercise? Yes No
 Have you ever had chest pain during or after exercise? Yes No
 Do you tire more quickly than your friends during exercise? Yes No
 Have you ever had high blood pressure? Yes

Have you ever been told you have a heart murmur? Yes No
 Have you ever had racing of your heart or skipped heart beats? Yes No
 Has anyone in your family died of heart problems or a sudden death before age 50? Yes No
 Has anyone in your immediate family been diagnosed with any cardiac conditions? Yes No

Please explain all YES answers _____

6. Do you have any skin problems (itching, rashes, acne)? Yes No
 If yes, explain: _____

7. Have you ever had a head injury, concussion, headaches, or dizziness? Yes No
 If yes, explain: _____

Have you ever been knocked out or unconscious? Yes No
 If yes, explain: _____

Have you ever had a seizure, convulsions, or epilepsy? Yes No
 If yes, explain: _____

Have you ever had a stinger, burner or pinched nerve? Yes No
 If yes, explain: _____

8. Have you ever had heat or muscle cramps? Yes No
 If yes, explain: _____

Have you ever been dizzy or passed out in the heat? Yes No
 If yes, explain: _____

Name _____

Preparticipation Evaluation

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9. Do you have trouble breathing or do you cough during or after activity? Yes No
If yes, explain: _____

10. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards) etc? Yes No
If yes, explain: _____

Do you have a pin, screw, or plate in your body? Yes No
If yes, explain: _____

11. Have you had any problems with your eyes or vision? Yes No
If yes, explain: _____

Do you wear glasses or contacts or protective eye wear? Yes No
If yes, explain: _____

Do you have a hearing impairment? Yes No
If yes, explain: _____

Do you wear any dental appliances? Yes No
If yes, explain: _____

12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries to any bones or joints? Yes No

CIRCLE: Head Shoulder Thigh Neck Elbow Knee Chest Forearm
 Shin/Calf Back Wrist Ankle Hip Hand Foot

Provide dates and explanations for circled items: _____

13. Have you had any other medical problems (mono, diabetes, asthma, TB, measles)? Yes No
If yes, explain: _____

14. Have you had a medical problem or injury since your last evaluation? Yes No
If yes, explain: _____

15. Do you have diabetes? Yes No

16. Are you missing one of a set of paired organs (kidneys, eyes, testicles)? Yes No
If yes, explain: _____

17. Have you ever had a head or neck injury? Yes No
If yes, explain: _____

Have you ever had your head or neck x-rayed? Yes No
If yes, explain: _____

