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 No
   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:______________________________
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:__________________________

11. Have you had any problems with your eyes or vision? 
    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:__________________________

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