PHYSICAL EVALUATION HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18). Responses are used solely for healthcare purposes.

Name: _____ **Date of Birth:** _____ **Date of Examination:** _____

Sex (F or M): _____ **Social Security Number:** _____ **Student ID Number:** _____

Residence Status: □ Resident □ Commuter **(For student-athletes only) Sport(s):** _____

List past and current medical conditions.

_____

_____

Have you ever had surgery? If yes, list all past surgical procedures.

_____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (i.e., medicines, pollen, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	YES	NO
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		
9. Do you get light-headed or feel shorter of breath than your peers during exercise?		
10. Have you ever had a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	UNSURE	YES	NO
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS ABOUT YOU	YES	NO
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS ABOUT YOU	**YES**	**NO**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Have you ever been diagnosed with asthma?		
18. Have you ever been diagnosed with tuberculosis (TB)?		
19. Have you ever had a positive TB skin test?		
20. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
21. Do you have groin pain, or a painful bulge/hernia in the groin area?		
22. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
23. Have you ever had or do you have any skin diseases or conditions?		
24. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
25. Have you ever been diagnosed with epilepsy?		
26. Have you ever been diagnosed with severe headaches or migraines?		
27. Do you have any history of stroke, paralysis, or neurologic conditions?		
28. Have you ever experienced numbness, tingling, or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
29. Have you ever become ill while exercising in the heat?		
30. Have you ever had sinusitis or chronic sinus infections?		
31. Have you ever been diagnosed with diabetes?		
32. Do you have any history of hepatitis, liver disease, or jaundice?		
33. Have you ever been diagnosed with a sexually transmitted infection (STI)?		
34. Do you or anyone in your family have sickle cell trait or disease?	UNSURE	

Please continue the Physical Evaluation History Form on the next page. →

35. Have you ever had or do you have any problems with your eyes or vision?		
36. Do you wear or have glasses or contacts?		
37. Have you ever had or do you have any problems with your ears or hearing?		
38. Do you wear a hearing aid?		
39. Have you had any recent unplanned weight loss or gain?		
40. Do you worry about your weight?		
41. Are you trying to or has anyone recommended that you gain or lose weight?		
42. Are you on a special diet or do you avoid certain types of foods or food groups?		
43. Have you ever had an eating disorder?		

LIFESTYLE QUESTIONS		**YES**	**NO**
44. Do you feel safe at your home or residence?	**UNSURE**		
45. Do you regularly use cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?			
46. Do you drink alcohol or use recreational drugs?			
47. Have you ever taken anabolic steroids?			
48. Have you ever taken any supplements to help you gain or lose weight or improve your performance?			
MALE QUESTIONS ONLY (Optional/Confidential)		**YES**	**NO**
1. Do you have testicular or groin pain?			
2. Have you experience pain, tenderness, or discomfort in the testicles or scrotum?			
3. Have you noticed any enlargement, discoloration, or asymmetry of the testicles?			
4. Have you experience pain associated with physical activity or urination?			
FEMALE QUESTIONS ONLY (Optional/Confidential)		**YES**	**NO**
1. Have you ever had a menstrual period?			
2. How old were you when you had your first menstrual period?			
3. When was your most recent menstrual period?			
4. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

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Reviewed By: _____

(Qualified Healthcare Professional Signature)

Date Reviewed: _____

Immunizations

Only needs to be submitted once upon initial entry

All students must provide a complete copy of childhood immunizations. You may ask your physician's office to send a copy of your immunization records to Thomas More University Campus Health via secure fax: (859) 344-3629

Privacy

The information contained within this document is strictly for the use of Thomas More University Campus Health and Sports Medicine. Limited health-related information may be shared with Residence Life personnel when necessary to support student health and safety. This information will not be released to anyone without your written consent. Your protected health information will not be shared with professors or other college personnel without written authorization.

I understand that Thomas More University Campus Health Services may consult with members of the healthcare team to ensure quality treatment and continuity of care, including counseling staff and other clinical personnel (e.g. sports medicine staff) who may be part of the treatment team.

I understand that I have the right to restrict the use and disclosure of my protected health information, and that I may revoke my consent at any time by giving written notification.

□ **YES** □ **NO** I consent to information regarding my care to be transmitted electronically (e.g. through TMU email).

□ **YES** □ **NO** I authorize Thomas More University Campus Health and Public Safety to provide emergency medical care, and to exercise professional judgment in securing emergency medical assistance and/or transportation when deemed necessary.

□ **YES** □ **NO** I acknowledge and understand that I am financially responsible for any and all medical expenses incurred as a result of illnesses or injuries not related to Thomas More University Athletics.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of Student: _____ **Date:** _____

Signature of Parent/Guardian (if student is under 18): _____ **Date:** _____