# Hill College Sports Medicine

## PREPARTICIPATION MEDICAL HISTORY FORM

**Athletes MUST complete this form and take with them to physician when obtaining physical.**

**Name:** _____ **Date:** _____

| General Health | Answer | | Explanation of "YES" Answers including date |
|---|---|---|---|
| 1. Have you had a medical illness or injury in the past year? | Yes | No | |
| 2. Have you been hospitalized in the past year? | Yes | No | |
| 3. Are you missing any paired organs? | Yes | No | |
| 4. Are you currently under doctor's care? | Yes | No | |
| 5. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? | Yes | No | |
| 6. Do you have any allergies? (pollen, medicine, food, insects) | Yes | No | |
| 7. Do you have any current skin problems? (itching, rashes, excessive acne, warts, fungus or blisters) | Yes | No | |
| 8. Have you ever become ill from exercising in the heat? (heat exhaustion, heat stroke) | Yes | No | |
| 9. Have you ever had problems with your eyes or vision? | Yes | No | |
| 10. Have you ever gotten unexpectedly short of breath with exercise? | Yes | No | |
| 11. Do you have asthma? | Yes | No | |
| 12. Do you have seasonal allergies requiring medical treatment? | Yes | No | |
| 13. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position?(knee brace, foot orthotics, retainer, hearing aide) | Yes | No | |
| 14. Do you want to weight less or more than you do now? | Yes | No | |
| 15. Have you ever been diagnosed with or tested for sickle cell trait or cell disease? | Yes | No | |
| **Neurovascular** | **Answer** | | **Explanation of "YES" Answers including date** |
| 1. Have you ever had a head injury or concussion? | Yes | No | |
| If yes, how many times? | | | |
| If yes, when was last concussion? (month and year) | | | |
| How severe was each concussion including symptoms experienced, treatment received and time held out of athletics participation. | | | |
| 2. Have you ever been knocked out, become unconscious, or lost your memory? | Yes | No | |
| 3. Have you ever had a seizure? | Yes | No | |
| 4. Do you have frequent or severe headaches? | Yes | No | |
| 5. Have you ever had numbness or tingling in your arms, hands, legs or feet? | Yes | No | |
| 6. Have you ever had a stinger, burner or pinched nerve? | Yes | No | |

| Cardiovascular | Answer | | Explanation of "YES" Answers including date |
|---|---|---|---|
| 1. Have you ever been dizzy during or after exercise? | Yes | No | |
| 2. Have you ever had prior testing for the heart ordered by a physician? | Yes | No | |
| 3. Have you ever passed out/fainted during or after exercise? | Yes | No | |
| 4. Have you ever had chest pain during or after exercise? | Yes | No | |
| 5. Do you get tired more quickly than your teammates during exercise? | Yes | No | |
| 6. Have you ever experienced racing of your heart or skipped heartbeats? | Yes | No | |
| 7. Do you or have you ever had high blood pressure or cholesterol? | Yes | No | |
| 8. Have you ever been told you have a heart murmur? | Yes | No | |
| 9. Has any family member or relative died of heart problems | | | |
| or of sudden unexpected death before age 50? | Yes | No | |
| 10. Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc) Marfan's syndrome, or abnormal heart rhythm? | Yes | No | |
| 11. Have you had a severe viral infection (myocarditis or mononucleosis) within the last month? | Yes | No | |
| 12. Has a physician ever denied or restricted your participation in sports for any heart problems? | Yes | No | |
| **Orthopedic** | **Answer** | | **Explanation of "YES" Answers including date** |
| 1. Have you ever had a sprain, strain or swelling after injury? | Yes | No | |
| If yes, explain in further detail: body part injured, date of injury, extent of injury, if limited athletic participation and if participation was limited, for how long. | | | |
| 2. Have you broken or fractured any bones or dislocated any joints? | Yes | No | |
| **Females Only** | **Answer** | | |
| 1. When was you first menstrual period? | | | |
| 2. When was your most recent menstrual period? | | | |
| 3. How much time do you usually have from the start of one period to the start of another? | | | |
| 4. How many periods have you had in the last year? | | | |
| 5. What was the longest time between periods in the last year? | | | |

Agree to the statements below by initialing in the blanks and sign and date.

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

_____ I understand that the preparticipation medical history and physical forms are merely screening tools in determining overall health prior to athletic participation and not a complete medical physical and thus, not all medical conditions and illnesses may be observed.

_____ I understand that failure to provide truthful answers to the above questions could cause complications to preexisting injuries, illnesses or conditions and Hill College will NOT be responsible for either preexisting injuries or complications that arise from preexisting injuries.

_____ _____ _____

Student-Athlete Signature | Printed Name | Date

July 6, 2021

# Hill College Athletics

## Pre-Participation Student-Athlete COVID-19 Screening

**To be completed prior to pre-participation physical and presented to healthcare practitioner for review during physical exam.**
**To be submitted to Athletic Department as attachment to physical exam document.**

Name: _____ _____ ____/____/_____
Last First Date of Birth (mm/dd/yyyy)

Please complete this form to assess your potential exposure / possession of COVID-19 and other illness.

Are you currently free from all illnesses? Yes NO (circle one)

Prior to today, have you experienced or are you currently experiencing any of the following:

| Symptom | YES | NO | LENGTH OF SYMPTOME (if yes) | EXPLANATION (has symptom resolved and, if so, when) |
|---|---|---|---|---|
| Fever | | | | |
| Body Chills | | | | |
| Extreme Level of Fatigue | | | | |
| Cough | | | | |
| Pain / Difficulty Breathing | | | | |
| Shortness of Breath | | | | |
| Sore Throat | | | | |
| Body / Muscle Aches | | | | |
| Loss of Taste | | | | |
| Loss of Smell | | | | |
| Changes to Vision / Eye Discharge | | | | |

| QUESTIONS | YES | NO |
|---|---|---|
| 1. If you answered YES to any of the above questions, did you experience a suspected exposure to COVID-19 2-14 days prior | | |
| 2. Have you had any direct contact with anyone who lives in or has visited a place where COVID-19 is spreading and/or is an area reporting an increased number of COVID-19 cases (i.e. "hot spots")? | | |
| 3. Have you had any direct contact with someone what has a suspected or lab confirmed case of COVID-19? | | |
| 4. Prior to today, have you self-quarantined due to suspected symptoms or exposure of COVID-19? | | |
| 5. Prior to today, have you been living in, or have you visited an area reporting an increased number of COVID-19 cases (i.e. hotspots)? | | |

Explanations: Please explain any yes question above including how and when including dates and your current status:

Have you previously been or are you currently diagnosed with COVID-19? YES NO (circle one) Date of Diagnosis (if yes): ___ / ___ / ___

If you answered YES, attach all paperwork confirming diagnosis and date of recovery or current status. **DO NOT** report to campus if you are currently diagnosed and under suspicion of contracting COVID-19. If you fall under this category, you must be completely recovered with medical documentation stating so prior to reporting to campus.

Please list any countries/states/cities you have traveled to since March 15th, 2020 and dates you were there:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____
4. _____ _____ Dates: _____ (add more on back, if applicable)

I understand the Novel Coronavirus, COVID-19, is a new worldwide pandemic affecting everyone around the world and is constantly evolving. As so, I also understand, that recommendations will evolve, and that today's recommendations may not be the same tomorrow. With this in mind, I understand that Hill College and the Hill College Athletics Department follow and utilize the recommendations and guidance of the Centers for Disease Control (CDC), the Health and Human Services (HHS), the Texas Department of Health (TDH) and the National Junior College Athletics Association (NJCAA) in implementing a plan to reduce the possibility of infection of COVID-19 as well as all other forms of infectious disease, and so, I voluntarily choose to participate in the Hill College Athletics Programs and understand that there is not any way to fully prevent becoming infected with COVID-19 or any other infectious disease.

Student-Athlete Signature: _____ Date: _____

# Hill College Sports Medicine

## PREPARTICIPATION PHYSICAL EXAMINATION FORM

Last Name: _____ First Name: _____

Date of Birth: _____ Sport: _____ Freshman / Sophomore (circle one)

***ATHLETES PLEASE DO NOT WRITE BELOW THIS LINE FOR MEDICAL PERSONNEL ONLY***

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Height: _____ inches Weight: _____ lbs BP: _____/_____ Pulse: _____ bpm

Vision: (R) _____ / _____ (L) _____ / _____ (Both) _____ / _____ Corrected? Y / N

| | NORMAL | ABNORMAL FINDINGS | ADDITIONAL COMMENTS |
|---|---|---|---|
| **MEDICAL** | | | |
| Appearance | | | |
| Eyes/Ears/Nose/Throat | | | |
| Lumph Nodes | | | |
| Heart-Auscultation of the heart in the supine position. | | | |
| Heart-Auscultation of the heart in standing position | | | |
| Heart-Lower extremity pulses | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia (males only) | | | |
| Skin | | | |
| Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis) | | | |
| **MUSCULOSKELETAL** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |
| Other | | | |
| **RECOMMENDED TEST/NOT REQUIRED** | | | |
| Electrocardiogram (ECG) | | | |
| Sickle Cell Trait | | | |

**CLEARED** **NOT CLEARED** **CLEARANCE PENDING** (comments below)

Comments: _____

I have reviewed the student-athlete's COVID-19 screening form and they do not appear to have any concerns.

**Physician's Printed Name:** _____ **Phone #:** _____

**Physician's Signature:** _____ **Date:** _____

July 6, 2021