



Regent University

PPE Medical Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sport \_\_\_\_\_

Personal History (Circle yes or no and explain all "yes" answers below)

Exertional chest pain/discomfort	YES	NO
Unexplained syncope/near syncope	YES	NO
Excessive exertional and unexplained dyspnea/fatigue associated with exercise	YES	NO
Prior recognition of a heart murmur	YES	NO
Elevated systemic blood pressure	YES	NO
Prior surgery	YES	NO
Prior hospitalization (over-night)	YES	NO
Ongoing Medical Conditions (diabetes, asthma, scoliosis, etc.)	YES	NO

Please explain: \_\_\_\_\_

Family History (Circle yes or no and explain all "yes" answers below)

Premature death (sudden and unexpected) before the age of 50 due to heart disease	YES	NO
Disability from heart disease in a close relative age 50 years old or younger	YES	NO
Specific knowledge of certain cardiac conditions in family members: hypertrophic or dilated cardiomyopathy, long QT syndrome or other ion channelopathies, Marfan's syndrome or clinical important arrhythmias	YES	NO

Please explain: \_\_\_\_\_

Cardiovascular Risk Factors (Circle yes or no and explain all "yes" answers below)

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 get tired more quickly than your friends do during exercise	YES	NO
Have you ever had racing of your heart or skipped heartbeats	YES	NO
Have you ever been told you have high blood pressure or high cholesterol	YES	NO
Have you had a severe viral infection (myocarditis or mononucleosis) in the last month	YES	NO

Please explain: \_\_\_\_\_

Has a physician ever denied or restricted your participation in sports for any heart problem **YES** **NO**

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Student-athlete signature if 18 years or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Parent signature if 17 years or younger)

\_\_\_\_\_  
Date



### Pre- Participation Physical Examination

Name \_\_\_\_\_ Date of Exam \_\_\_\_\_ Sport \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Weight	Height		Blood Pressure	Pulse	
Eyes	R	L	Femoral Pulse		
<b>Skin</b>			Pupils (Equal/Unequal)	R	L
Rashes					
Other					
<b>Head</b>					
<b>Ears</b>					
Tympanic Membrane					
Canal					
Other					
<b>Nose</b>					
Septal Defect					
Obstruction					
Throat and Mouth					
<b>Neck</b>					
Lymph Nodes					
<b>Lungs</b>					
Breath Sounds					
Other					
<b>Heart</b>					
Size					
Rate					
Rhythm					
Murmurs					
Physical Stigmata of Marfan's Syndrome	Y or N				
Other					
<b>Abdomen</b>					
Liver					
Spleen					
Masses					
Tenderness					
Other					
<b>Hernia</b>					
<b>Genitalia</b>					
Hydrocele					
Variocele					
<b>Extremities</b>					
Symmetry					

<b>Neurological</b>	
Reflexes	
Gait	
Other	
<b>Musculo-Skeletal</b>	
Joint Dislocation	
Weakness	
Surgical Scars	
Other	
<b>Defects and Remarks</b>	
<b>Orthopedic Evaluation</b>	
<b>Special Equipment</b>	
<b>Regular Medications</b>	
<b>Allergies/Drug Allergies</b>	
<b>Accepted</b>	
Rejected	
Hold for Further Testing (please indicate)	

Recommendation: \_\_\_\_\_  
 \_\_\_\_\_

I hereby certify that this athlete was examined by me.

Name of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

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

Phone: (\_\_\_\_) \_\_\_\_\_

**\*\*Signature of Physician: \_\_\_\_\_**

**\*\*Please make sure accepted, rejected, or hold for further testing has been checked and that the physician has signed the first page of the physical and the third page of the physical before turning in your physical\*\***