Florence-Darlington Technical College
Office of Intercollegiate Athletics
P. O. Box 100548
Florence, SC 29501

FDTC PREPARTICIPATION PHYSICAL EXAM

VITAL SIGNS **R L**

HT WT (SKINFOLD mm) PULSES: WRIST
VISION R 20/ L 20/ FEM
(CORRECTED) DENTAL HEART RATE
R 20/ L 20/ BP

PHYSICAL	**CK NEG**	**RECORD ABNORMALS**	**MUSCLSKEL**	**CK NEG**	**RECORD ABNORMALS**
DEFORMITY			**ROM INSTABIL**		
APPEARANCE			C SPINE		
PUPILS			T SPINE		
EENT			LS SPINE		
LUNG			SHOULDER		
			ELBOW		
HEART			WRIST		
			HAND		
ABDOMEN			HIP		
GU			KNEE		
SKIN			ANKLE		
LYMPH NODES			FOOT		

NOTES:

CLEARED (I)___ CROSS OUT SPORT NOT PERMITTED
BASEBALL SOFTBALL

NEEDS FURTHER EVAL (II)____ EVALUATION BY_____
REHAB BY_____
SECONDARY CLEARANCE (I)_____MD or DO Date_____

NOT CLEARED(III)___ REASON:
COLLISION_____ CONTACT_____ NONCONTACT_____
STRENUOUS_____MODERATELY STRENUOUS_____NONSTRENUOUS_____

NAME OF PHYSICIAN OR FACILITY: _____
ADDRESS: _____ PHONE: _____

SIGNATURE_____MD or DO Date_____

HISTORY **FDTC** PREPARTICIPATION PHYSICAL EVALUATION **DATE OF EXAM**_____

Name_____ Sex_____Age_____ Date of Birth _____

Address_____ Phone _____

Personal Physician_____

IN CASE OF EMERGENCY, CONTACT: Name_____ Relationship_____

Phone (H)_____ (W)_____

☐ ☐ ☐ ☐☐☐ ☐☐☐ ☐☐☐ ☐☐

I II III A B C 1 2 3 a b c + - **Social Security #:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

PPE Inj Act FT PE

FILL YES / NO BOXES **Explain "Yes" answers below.** **ircle questions you don't know the answers to completely.**

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
	Do you have an ongoing or chronic illness?	☐	☐
2.	Have you ever been hospitalized overnight?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
	Have you ever had a rash or hives develop during or after exercise?	☐	☐
5.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever been dizzy during or after exercise?	☐	☐
	Have you ever had chest pain, chest discomfort, or unplained shortness of breath during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐
	Has any relative younger than 50 ever had disability from heart or cardiovascular disease ?	☐	☐
	Do you have, or do you know any family member or relative with ANY heart condition (Marfans, cardiomyopathy, or arrhythmia – irregular heartbeat)	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8.	Have you ever become ill from exercising in the heat?	☐	☐
9.	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐

Explain any "Yes" answers here: _____

_____

_____**C**

		Yes	No
10.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
11.	Have you had any problems with your eyes or vision?	☐	☐
	Do you wear glasses, contacts, or protective eyeware?	☐	☐
12.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

ANSWER BELOW		**For Examiner Use Only**							
Please MARK & FILL appropriate box of problem areas. Explain below in the space provided what you understood your injury to be. Do not mark spaces to right of this section.		Overuse	Strain	Sprain	Contusion	Concussion	Dislocation	Laceration	Fx
❻	Head								
	Neck								
❻	Back								
❻	Shoulder/Arm								
❻	Elbow/Forearm								
❻	Wrist/Hand/Finger								
❻	Hip/Thigh								
❻	Knee								
❻	Leg/Ankle								
❻	Foot/Toe								

13.	Do you want to weigh more or less than you do now?	☐	☐
	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14.	Do you feel stressed out?	☐	☐

15. Record the dates of your most recent immunizations (shots) for:
Tetanus_____ Measles_____
Hepatitis B_____ Chickenpox_____

FEMALES ONLY

16. When was your first menstrual period?_____
When was your **most recent** menstrual period?_____
How much time do you usually have from the start of one period to the start of another?_____
How many periods have you had in the last year?_____
What was the longest time between periods in the last year?_____

Explain any INJURY here: _____

By signing this, I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Sign on opposite page.