

## **MESALANDS COMMUNITY COLLEGE**

Wind Energy Technology Preparticipation Physical Evaluation History Form



## DATE OF EXAM

Name	\$	Sex		_ Age Date of birth		_
Address				Phone		-
Personal physician						-
In case of emergency, contact						
NameRelationship				_Phone (H) (W)		-
Explain "Yes" answers below.	1					
Circle questions you don't know the answers to.	Yes	No			Yes	No
<ol> <li>Has a doctor ever denied or restricted your participation in physical activities for any reason?</li> </ol>			24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
<ol> <li>Do you have an ongoing medical condition (like diabetes or asthma)?</li> </ol>			25.	Is there anyone in your family who has asthma?		
<ol> <li>Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?</li> </ol>			26.	Have you ever used an inhaler or taken asthma medicine?		
4. Do you have allergies to medicines, pollens, foods, or			27.	Were you born without or are you missing a		
<ul><li>stinging insects?</li><li>5. Have you ever passed out or nearly passed out</li></ul>			28.	kidney, an eye, a testicle, or any other organ? Have you had infectious mononucleosis (mono)		
DURING exercise? 6. Have you ever passed out or nearly passed out			29.	within the last month? Do you have any rashes, pressure sores, or other		
AFTER exercise? 7. Have you ever had discomfort, pain, or pressure in			30.	skin problems? Have you had a herpes skin infection?		
your chest during exercise? 8. Does your heart race or skip beats during exercise?				Have you ever had a head injury or concussion?		
<ol> <li>Has a doctor ever told you that you have (check all that apply):</li> </ol>				Have you been hit in the head and been confused or lost your memory?		
□High blood pressure □A heart murmur □High cholesterol □A heart infection			33.	Have you ever had a seizure?		
10. Has a doctor ever ordered a test for your heart?			34.	Do you have headaches with exercise?		
<ul><li>(for example, ECG, echocardiogram)</li><li>11. Has anyone in your family died for no apparent reason?</li></ul>			35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or		
12. Does anyone in your family have a heart problem?			36.	falling? Have you ever been unable to move your arms or		
<ol> <li>Has any family member or relative died of heart problems or of sudden death before age 50?</li> </ol>			37.	legs after being hit or falling? When exercising in the heat, do you have severe muscle cramps or become ill?		
14. Does anyone in your family have Marfan syndrome?			38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
15. Have you ever spent the night in a hospital?			39.	Have you had any problems with your eyes or vision?		
16. Have you ever had surgery?			40.	Do you wear glasses or contact lenses?		
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss work? If yes, circle affected area below:			41.	Do you wear protective eyewear, such as goggles or a face shield?		
<ol> <li>Have you had any broken or fractured bones or dislocated joints? If yes, circle below:</li> </ol>			42.	Are you happy with your weight?		
<ol> <li>Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation,</li> </ol>			43.	Are you trying to gain or lose weight?		
physical therapy, a brace, a cast, or crutches? If yes, circle below:			44.	Has anyone recommended you change your weight or eating habits?		
Head Neck Shoulder Upper Arm	1		45.	Do you limit or carefully control what you eat?		
ElbowForearmHand/fingersChestUpper backLower backHipThigh			46.	Do you have any concerns that you would like to		
KneeCalf/ShinAnkleFoot/toes20. Have you ever had a stress fracture?			FEI	discuss with a doctor? MALES ONLY		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?				Have you ever had a menstrual period?		
22. Do you regularly use a brace or assistive device?			48.	How old were you when you had your first		
23. Has a doctor ever told you that you have asthma or allergies?			49.	menstrual period? How many periods have you had in the last 12 months?		
Explain "Yes"answers here:						

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

Signature of participant:\_\_\_

Signature of parent/guardian:\_\_\_ (If under 18)

\_ Date:\_