

# Towson University – Department of Dance

## PRE-PARTICIPATION PHYSICAL EVALUATION

Allergies:

Date of Exam:

### HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Academic Year in School: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

PLEASE EXPLAIN ANY 'YES' ANSWERS BELOW. CIRCLE THE QUESTIONS YOU DON'T KNOW THE ANSWERS TO:

1. Have you had medical illness or injury since your last checkup? Yes No

\_\_\_\_\_

2. Have you ever been hospitalized overnight? Yes No

\_\_\_\_\_

Have you ever had surgery? Yes No

\_\_\_\_\_

3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills, or using an inhaler?

Yes No

\_\_\_\_\_

4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?

Yes No

\_\_\_\_\_

5. Have you ever had a rash or hives develop during or after exercise? Yes No

\_\_\_\_\_

6. Have you ever been dizzy during or after exercise? Yes No

\_\_\_\_\_

7. Have you ever had chest pain during or after exercise? Yes No

\_\_\_\_\_

8. Have you ever had chest pain during or after exercise? Yes No

\_\_\_\_\_

9. Do you get tired more quickly than your friends do during exercise? Yes No

\_\_\_\_\_

10. Have you ever had racing of your heart or skipped heartbeats? Yes No

\_\_\_\_\_

11. Have you had high blood pressure or high cholesterol?

Yes No

\_\_\_\_\_

\_\_\_\_\_

12. Have you ever been told you have a heart murmur?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

13. Has any family member or relative died of heart problems? Yes No

\_\_\_\_\_  
\_\_\_\_\_

14. Do you use any special protective corrective devices that are not usually used by those in dance (for example, knee brace, ankle brace, foot orthotics or special wraps)? Yes No

\_\_\_\_\_  
\_\_\_\_\_

15. Have you had any problems with your eyes or vision?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

16. Do you wear glasses, contacts or protective eyewear?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

17. Have you ever had a sprain or swelling after injury?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

18. Have you broken or fractured any bones or dislocated any joints?

Yes no

\_\_\_\_\_  
\_\_\_\_\_

19. Have you had any other problems with pain or swelling of joints? Yes No

Head Elbow Forearm Thigh  
Back Wrist Chest Hand Shin/Calf  
Upper Arm Finger Foot Toes

\_\_\_\_\_  
\_\_\_\_\_

20. Do you want to weigh more or less than you do now?

More Less Change Desired.

\_\_\_\_\_  
\_\_\_\_\_

21. Do you lose weight regularly to meet weight or appearance requirements?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

22. Do you feel stressed out now?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

23. Do you feel stressed out during dance activities?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

24. Record the dates of your most recent immunization (Shots) for: Tetanus: \_\_\_\_\_

Hepatitis B \_\_\_\_\_

Chickenpox \_\_\_\_\_

25. Has a physician ever denied or restricted your participation in sports, exercise, performing arts for any heart problems? Yes No

\_\_\_\_\_  
\_\_\_\_\_

26. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

27. Have you ever had head injury or concussion?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

28. Have you ever been knocked out, become unconscious, or lost your memory?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

29. Have you had a severe viral infection (for example, Myocarditis or mononucleosis)?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

30. Do you have frequent or severe headaches?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

31. Have you ever had numbness or tingling in your feet?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

32. Have you ever become ill from exercising in the heat?

Yes No

\_\_\_\_\_  
\_\_\_\_\_

33. *Have you ever had a stinger, burner or pinched nerve?*

Yes                      No

\_\_\_\_\_

\_\_\_\_\_

34. *Do you cough, wheeze or have troubling breathing during or after activity?*

Yes                      No

\_\_\_\_\_

\_\_\_\_\_

35. *Do you have asthma?*      Yes                      No

\_\_\_\_\_

\_\_\_\_\_

36. *Do you have seasonal allergies that require medical treatment?*

Yes                      No

\_\_\_\_\_

\_\_\_\_\_

37. *Have you ever had surgery?*

Yes                      No

\_\_\_\_\_

\_\_\_\_\_

38. *Do you have an ongoing or chronic illness?*

Yes                      No

\_\_\_\_\_

\_\_\_\_\_

39. *When was your first menstrual period?*

\_\_\_\_\_

\_\_\_\_\_

40. *When was your most recent menstrual period?*

\_\_\_\_\_

\_\_\_\_\_

41. *How much time do you usually have from the start of one period to another?*

\_\_\_\_\_

\_\_\_\_\_

42. *How many periods have you had in the last year?*

\_\_\_\_\_

\_\_\_\_\_

43. *What was the longest time between periods in the last year?*

\_\_\_\_\_

\_\_\_\_\_

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

Dancer \_\_\_\_\_

Parent/Guardian (dancer under 18) \_\_\_\_\_

\_\_\_\_\_

Towson University Dance Department  
**PREPARTICIPATION PHYSICAL EVALUATION**

DATE OF EXAM \_\_\_\_\_

**PHYSICAL EXAMINATION**

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_

Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected? Y N Pupils: Equal Unequal

MEDICAL	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
MUSCULOSKELETAL		
C Spine		
T Spine		
LS Spine		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

**CLEARANCE**

Cleared for full participation

Cleared after completing evaluation/rehabilitation for:

---

---

---

---

---

---

---

Not cleared for: \_\_\_\_\_

Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

---

---

---

---

---

---

---

Name of physician (print or type) \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Signature of Physician \_\_\_\_\_,

M.D. or D.O.