

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

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

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ )

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

\*Multiple-examiner set-up only.  
 +Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

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

EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

# Preparticipation Physical Evaluation

# HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal Physician \_\_\_\_\_  
**In case of emergency, contact:**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone(W) \_\_\_\_\_

**Explain "Yes" answers below.  
 Circle questions you don't know the answers to.**

- |  |            |          |           |           |            |               |               |       |            |            |     |       |      |            |       |            |  |
|--|------------|----------|-----------|-----------|------------|---------------|---------------|-------|------------|------------|-----|-------|------|------------|-------|------------|--|
| <p><b>Yes No</b></p> <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Has a doctor ever told you that you have (check all that apply):<br/> <input type="checkbox"/> High blood pressure      <input type="checkbox"/> A heart murmur<br/> <input type="checkbox"/> High cholesterol      <input type="checkbox"/> A heart infection</p> <p>10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> <input type="checkbox"/></p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Have you ever had surgery? <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: <input type="checkbox"/> <input type="checkbox"/></p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> <input type="checkbox"/></p> <p>19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: <input type="checkbox"/> <input type="checkbox"/></p> <table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td>Head</td><td>Neck</td><td>Shoulder</td><td>Upper Arm</td><td>Elbow</td><td>Forearm</td><td>Hand/ Fingers</td><td>Chest</td> </tr> <tr> <td>Upper Back</td><td>Lower Back</td><td>Hip</td><td>Thigh</td><td>Knee</td><td>Calf/ Shin</td><td>Ankle</td><td>Foot/ Toes</td> </tr> </table> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> <input type="checkbox"/></p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> <input type="checkbox"/></p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> <input type="checkbox"/></p> <p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> <input type="checkbox"/></p> | Head       | Neck     | Shoulder  | Upper Arm | Elbow      | Forearm       | Hand/ Fingers | Chest | Upper Back | Lower Back | Hip | Thigh | Knee | Calf/ Shin | Ankle | Foot/ Toes | <p><b>Yes No</b></p> <p>24. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> <input type="checkbox"/></p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> <input type="checkbox"/></p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> <input type="checkbox"/></p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> <input type="checkbox"/></p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> <input type="checkbox"/></p> <p>30. Have you had a herpes skin infection? <input type="checkbox"/> <input type="checkbox"/></p> <p>31. Have you ever had a head injury or concussion? <input type="checkbox"/> <input type="checkbox"/></p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> <input type="checkbox"/></p> <p>33. Have you ever had a seizure? <input type="checkbox"/> <input type="checkbox"/></p> <p>34. Do you have headaches with exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> <input type="checkbox"/></p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> <input type="checkbox"/></p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> <input type="checkbox"/></p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> <input type="checkbox"/></p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> <input type="checkbox"/></p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> <input type="checkbox"/></p> <p>42. Are you happy with your weight? <input type="checkbox"/> <input type="checkbox"/></p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> <input type="checkbox"/></p> <p>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> <input type="checkbox"/></p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> <input type="checkbox"/></p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> <input type="checkbox"/></p> <p><b>FEMALES ONLY</b></p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> <input type="checkbox"/></p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 months? _____</p> <p>Explain "Yes" answers here: _____<br/>         _____<br/>         _____<br/>         _____</p> |
| Head   | Neck       | Shoulder | Upper Arm | Elbow     | Forearm    | Hand/ Fingers | Chest         |       |            |            |     |       |      |            |       |            |  |
| Upper Back   | Lower Back | Hip      | Thigh     | Knee      | Calf/ Shin | Ankle         | Foot/ Toes    |       |            |            |     |       |      |            |       |            |  |

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

Signature of Athlete \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

LAST NAME