

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.**

	Yes	No		Yes	No					
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>					
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>					
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>					
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	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"/>					
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>					
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>					
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>					
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>					
9. Has a doctor ever told you that you have (check all that apply):			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> High blood pressure			33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> High cholesterol			34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> A heart murmur			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"/>					
<input type="checkbox"/> A heart infection			36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>					
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>					
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	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"/>					
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>					
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>					
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>					
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>					
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>					
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"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>					
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>					
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"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>					
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest	FEMALES ONLY		
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes	47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	48. How old were you when you had your first menstrual period? _____					49. How many periods have you had in the last 12 months? _____		
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"/>	Explain "Yes" answers here:							
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	_____							
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____							

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 _____

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Revised 04-13-05

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*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only) +			
Skin			
MUSCULOSKELETAL			
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: _____

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CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

Cleared without restriction
 Cleared, with recommendations for further evaluations 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