

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION

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		
Lymph Nodes		
Heart		
Pluse		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

* Station-based examination only

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____
- _____
- Not Cleared for: _____ Reason: _____
- Recommendations: _____
- _____

Name of physican (print/type) _____ Date _____

Address _____ Phone _____

Signature of physican _____, MD or DO

Preparticipation Physical Evaluation

HISTORY

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal physician _____

In case of emergency, contact

Name _____ Relationship _____ Phone (H) _____ (W) _____

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

- | | 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? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you use any special protective or corrective equipment or devices that aren't usually used for you sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on you teeth, hearing aid)? |
| 2. Have you ever been hospitalized overnight?
Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any problems with your eyes or vision?
Do you wear glasses, contacts, or protective eyewear? |
| 3. Are you currently taking any prescription or non prescription (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 you performance? | <input type="checkbox"/> | <input type="checkbox"/> | 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?
<i>If yes, check appropriate box and explain below.</i> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip
<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh
<input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee
<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Skin/calf
<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle
<input type="checkbox"/> Upper arm <input type="checkbox"/> Foot |
| 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 during or after exercise?
Do you get tired more quickly than you friends do during exercise?
Have you 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 of sudden death before age 50?
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? | <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you feel stressed out? |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Record the dates of your most recent immunizations (shots) for:
Tetanus _____ Measles _____
Hepatitis B _____ Chickenpox _____ |
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES ONLY |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | 16. When was you first menstrual period? _____
When was you 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 last year? _____ |

Explain "Yes" answer here: _____

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 _____