Preparticipation Physical Evaluation

HISTORY

Date of Examination _____

Name _____ Sex _____ Age _____ Date of Birth _____

Grade ____ School Name _____ Sport/s _____

Address _____ Phone: _____

Personal Physician _____

In Case of Emergency, Contact Name _____ Relationship _____

Phone (H) _____ Phone (W) _____ Phone (M) _____

Explain "Yes" answers below.
Circle questions if answers are unclear to you

1 Have you had a medical illness or injury since your last check up or sports physical?
1 a Do you have an ongoing or chronic illness?
2 Have you ever been hospitalized overnight?
2 a Have you ever had surgery?
3 Are you currently taking any prescription or nonprescription (over-the--counter) medications or pills or using an inhaler?
3 a Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
4 Do you have any allergies (for example, to pollen, medicine, food, or stinging insects?
4 a Have you ever had a rash or hives develop during or after exercise?
5 Have you ever passed out during exercise?
5 a Have you ever been dizzy during or after exercise?
5 b Have you ever had chest pain during or after exercise?
5 c Do you get tired more quickly than your friends do during exercise?
5 d Have you ever had racing of your heart or skipped heartbeats?
5 e Have you had high blood pressure or high cholesterol?
5 f Have you ever been told you have a heart murmur?
5 g Has any family member or relative died of heart problems or of sudden death before age 50?
5 h Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
5 i Has a physician ever denied or restricted your participation in sports for any heart problems?
6 Has a physician ever denied or restricted your participation in sports for any heart problems?
7 Have you ever had a head injury or concussion?
7 a Have you ever been knocked out, become unconscious, or lost your memory?
7 b Have you ever had a seizure?
7 c Do you have frequent or severe headaches?
7 d Have you ever had numbness or tingling in your arms, hands, legs, or feet?
7 e Have you ever had a stinger, burner, or pinched nerve?
8 Have you ever become ill from exercising in the heat?
9 Do you cough, wheeze, or have trouble breathing during or after activity?
9 a Do you have asthma?
9 b Do you have seasonal allergies that require medical treatment?

10 Do you use any special protective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid?
11 Have you had any problems with your eyes or vision?
11 a Do you wear glasses, contacts, or protective eyewear?
12 Have you ever had a sprain, strain, or swelling after injury?
12 a Have you broke or fractured any bones or dislocated any joints?
12 b Have you had any other problems with pain or swelling muscles, tendons, bones, or joints?

If yes, check appropriate box and explain below

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm		☐ Foot

13 Do you want to weigh more or less than you do now?
13 a Do you lose weight regularly to meet weight requirements for your sport?
14 Do you feel stressed out?
15 Record the dates of your most recent immunizations (shots) for:

Tetanus Measles

Hepatitis B Chicken pox

FEMALES ONLY

16 When was your last menstrual period?
16 a When was your most recent menstrual period?
16 b How much time do you usually have from start of one period to the start of another?
16 c How many periods have you had in the last year?
16 d What was the longest time between periods in the last year?

Explain "Yes" Answers Here: Use Page Three

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

Athlete Signature _____ Parent/Guardian Signature _____ Date _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION

Name _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) ____ Pulse ____ BP _____

Vision R 20/ _____ L 20/ _____ Corrected: _____ Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance	☐		☐
Eyes/Ears/Nose/Throat	☐		☐
Lymph Nodes	☐		☐
Heart	☐		☐
Pulses	☐		☐
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 physician (print/type) _____ Date: _____

Address: _____ Telephone: _____

Signature of physician: _____ _____ ☐

Preparticipation Physical Evaluation

HISTORY

Name _____ Date of Birth _____

Explain "Yes" answers from Page One

Question (Example: 5a)	**Explanation**