

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

 _____</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 _____

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*
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: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

- 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

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