PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAM FORM

NAME ______________________ DATE OF BIRTH ______________________ AGE ________
HEIGHT ________ WEIGHT ________ % BODY FAT (OPTIONAL) ________________ PULSE ____________
BP ______ / ______ / ______ / ______
VISION R 20/ ______ L 20/ ______ CORRECTED: Y N PUPILS: EQUAL ______ UNEQUAL ____

Notes: ____

____

____

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MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/ ears/ nose/ throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
MUSCULOSKETAL			
Neck			
Back			
Shoulder/ arm			
Elbow/ forearm			
Wrist/ hand/ fingers			
Hip/ thigh			
Knee			
Leg/ ankle			
Foot/ toes			

*Multiple examiner set-up only.

Notes: ____

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CLEARANCE

☐ Cleared without restriction

☐ Cleared, with recommendations for further evaluation or treatment for: ______________________

____

☐ Not cleared for: ☐ All Sports ☐ Certain Sports: ______________________ Reason: __________

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____

EMERGENCY INFORMATION

Allergies: ____

Other Information: ____

Name of Physician: (print/ type/ stamp) ______________________ (M.D., D.O.) Date: ________

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name & address of collaborating physician or physician group:

Address: ______________________________________ Phone: ____________

Signature of Physician: ____

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

NAME ______ SEX ____ DATE OF BIRTH ______ AGE ____
ADDRESS ______ CITY ______ STATE ______ ZIP ______
PERSONAL PHYSICIAN ______
IN CASE OF EMERGENCY, CONTACT:
NAME ______ RELATIONSHIP ______ PHONE ______

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

	Question	YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have an ongoing medical condition (like diabetes or asthma)?		
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?		
4.	Do you have any allergies to medicines, pollens, food, or stinging insects?		
5.	Have you ever passed out or nearly passed out DURING exercise?		
6.	Have you ever passed out or nearly passed out AFTER exercise?		
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8.	Does you heart race or skip beats during exercise?		
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Does anyone in your family have a heart problem?		
13.	Has any family member or relative died of heart problems or of sudden death before age 50?		
14.	Does anyone in your family have Marfan syndrome?		
15.	Have you ever spent the night in a hospital?		
16.	Have you ever had surgery?		
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or a game? If yes, circle the affected area below.		
18.	Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below.		
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.		

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

	Question	YES	NO
20.	Have you ever had a stress fracture?		
21.	Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22.	Do you regularly use a brace or assistive device?		
23.	Has a doctor ever told you that you have asthma or allergies?		
24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25.	Is there anyone in your family who has asthma?		
26.	Have you ever used an inhaler or taken asthma medicine?		
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28.	Have you ever had infectious mononucleosis (mono) within the last month?		
29.	Do you have any rashes, pressure sores, or other skin problems?		
30.	Have you ever had a herpes skin infection?		
31.	Have you ever had a head injury or concussion?		
32.	Have you ever been hit in the head and been confused or lost your memory?		
33.	Have you ever had a seizure?		
34.	Do you have headaches with exercise?		
35.	Have you ever had burning, tingling, or weakness in your arms or legs after being hit or falling?		
36.	Have you ever been unable to move your arms or legs after being hit or falling?		
37.	When exercising in the heat, do you have severe muscle cramps or become ill?		
38.	Has a doctor told you that you or someone in your family has sickle cell trait or disease?		
39.	Have you had any problems with your eyes or vision?		
40.	Do you wear glasses or contact lenses?		
41.	Do you wear protective eyewear, such as goggles or a face shield?		
42.	Are you happy with your weight?		
43.	Are you trying to gain or lose weight?		
44.	Has anyone recommended that you change your weight or eating habits?		
45.	Do you limit or carefully control what you eat?		
46.	Do you have any concerns that you would like to discuss with a doctor?		
	FEMLAES ONLY		
47.	Have you ever had a menstrual period?		

48. How old were you when you had your first menstrual period? ______
49. How many periods have you had in the last 12 months? ______

Explain "Yes" answers here: ______

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

Signature of Athlete(Parent/ Guardian if under 18)______________ Date__________