

# Preparticipation Physical Evaluation

HISTORY

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) \_\_\_\_\_ (W) \_\_\_\_\_

Explain "Yes" answers below.

Circle questions you don't know the answers to.

- |                                                                                                                              | Yes                      | No                       |
|------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Have you had a medical illness or Injury since your last check up or sports physical?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an ongoing or chronic illness?                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery?                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a rash or hives develop during or after exercise?                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise?                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise?                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise?                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats?                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol?                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur?                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden death before age 50?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head Injury or concussion?                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious, or lost your memory?                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure?                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches?                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet?                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve?                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat?                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity?                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have asthma?                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies that require medical treatment?                                                               | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                                                                                                                                                                                                                 | Yes                      | No                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 10. Do you use any special protective or corrective 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)? | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                                         |                          |                          |
|---------------------------------------------------------|--------------------------|--------------------------|
| 11. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses, contacts, or protective eyewear?   | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                                                                              |                          |                          |
|----------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 12. Have you ever had a sprain, strain, or swelling after injury?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you broken or fractured any bones or dislocated any joints?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, check appropriate box and explain below</i>                                       |                          |                          |

- |                                    |                                  |                                    |
|------------------------------------|----------------------------------|------------------------------------|
| <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"/> Shin/calf |
| <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| <input type="checkbox"/> Upper arm |                                  | <input type="checkbox"/> Foot      |

- |                                                                          |                          |                          |
|--------------------------------------------------------------------------|--------------------------|--------------------------|
| 13. Do you want to weigh more or less than you do now?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |

- |                               |                          |                          |
|-------------------------------|--------------------------|--------------------------|
| 14. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
|-------------------------------|--------------------------|--------------------------|

15. Record the dates of your most recent immunizations (shots) for:
- |                   |                  |
|-------------------|------------------|
| Tetanus _____     | Measles _____    |
| Hepatitis B _____ | Chickenpox _____ |

## **FEMALES ONLY**

16. When was your first menstrual period? \_\_\_\_\_
- When was your 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 in the last year? \_\_\_\_\_

Explain "Yes" answers here:

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**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

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                  |        |                   |           |
| 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 \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD, Do, PAC, RNP, or DC

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