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_____Relaitonship_____Phone (H)_____(W)_____

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

	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 asthema)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, 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 your 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 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 tendinitis, that caused you to miss a practice or game? If yes, circle the affected area below.	☐	☐
18. Have you 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? Circle below.	☐	☐

HEAD	NECK	SHOULDER	UPPER ARM	ELBOW	FOREARM	HAND/ FINGERS	CHEST
UPPER BACK	LOWER BACK	HIP	THIGH	KNEE	CALF/SHIN	ANKLE	FOOT/ TOES

20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor every 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 had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you 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 numbness 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 sickle cell 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 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?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you first had your menstrual period?	_____	
49. How many period have you had in the past year?	_____	

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_____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 Pupiis: Equal _____ Unequal _____

Follow-Up Questions on More Sensitive Issues:	**YES**	**NO**
1. Do you feel stressed out or under a lot of pressure?	☐	☐
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	☐	☐
3. Do you feel safe?	☐	☐
4. Have you ever tried cigarette smoking, even 1 or 2 puffs?	☐	☐
5. Do you currently smoke?	☐	☐
6. During the past 30 days, did you use chewing tobacco, snuff, or dip?	☐	☐
7. During the past 30 days, have you had a least 1 drink of alcohol?	☐	☐
8. Have you ever taken steroid pills or shots without a doctor's prescription?	☐	☐
9. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐
10.Questions from theYouth Risk Behavior Survey (http://www.cc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.	☐	☐

NOTES:

_____

_____

_____

_____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary ✦			
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_____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza, poliomyelitis, pneumococcal; meningococcal; varicella)

☐ Up to date (see attached documentation) ☐ Not up to date **Specify**_____

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_____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza, poliomyelitis, pneumococcal; meningococcal; varicella)

☐ Up to date (see attached documentation) ☐ Not up to date **Specify**_____

Name of physician (print/type)_____**Date**_____

Address_____**Phone**_____

Signature of physician_____**, MD or DO**

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