

Preparticipation Physical Evaluation

Physical Examination

Name _____ Date of birth _____

Height _____ Weight _____ %of body fat (optional) _____ Pulse _____ BP _____ / _____ (_____/_____, ____/____)

Vision R20/____ L20/____ 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			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

CLEARED

Cleared after completing evaluation/rehabilitation for: _____

NOT Cleared for: _____ Reason: _____

Recommendation: _____

Name of Physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of Physician _____, M.D. or D.O.

Pre-participation Physical Evaluation

HISTORY

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of birth _____

Address _____

Personal Physician _____

In case of emergency, contact

Name _____ Relationship _____ Phone(home) _____ (work) _____

Explain "Yes" answers below.

Circle questions you don't know the answers to.

	YES	NO		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"/>	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e., knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight? Have you had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<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? Have you ever taken any supplements or vitamins to help you gain weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.		
4. Do you have any allergies (i.e., pollen, medicine, food, or stinging insects)? Have you ever had a rash or hives develop during or after exercises?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death below age 50? Have you had a severe viral infection (i.e., myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
6. Do you have any current skin problems (i.e., itching, rashes, acne, warts, fungus, blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Skin/calf
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
			13. Do you want to weigh more or less than you do now? 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 _____ Chicken pox _____		
			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:		

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

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____