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)_____(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 asthma)?	❒	❒
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	❒	❒
4. Do you have any 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 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 tendinitis, that caused you to miss a practice or game? If yes, circle 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? 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

20. Have you ever had a stress fracture?	❒	❒
21. Have you 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 as 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 every 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 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_____Signature of parent/guardian_____Date_____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name_____Date of birth_____

Height_____Weight_____% Body fax (optional)_____Pulse_____BP____/____ (____/____ ,_____/____)

Vision R 20/ ____ L 20/ ___ Corrected: Y N Pupils: 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? Do you currently smoke?	❒	❒
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?	❒	❒
6. During the past 30 days, have you had a least 1 drink of alcohol?	❒	❒
7. Have you ever taken steroid pills or shots without a doctor's prescription?	❒	❒
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	❒	❒
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.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 (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_____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influensa; 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_____

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❒ Cleared, with recommendations for further evaluation or treatment for:_____

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Recommendations:_____

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EMERGENCY INFORMATION
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❒ 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