

# 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) \_\_\_\_\_ Phone (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?                 | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)?                                 | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?                            | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 5. Have you ever passed out or nearly passed out DURING exercise?                                      | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 6. Have you ever passed out or nearly passed out AFTER exercise?                                       | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?                      | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 8. Does your heart race or skip beats during exercise?   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 9. Has a doctor ever told you that you have (check all that apply):                                    |                          |  |
| <input type="checkbox"/> High blood pressure   |                          | <input type="checkbox"/> A heart murmur    |
| <input type="checkbox"/> High cholesterol  |                          | <input type="checkbox"/> A heart infection |
| 10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)                | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 11. Has anyone in your family died for no apparent reason?   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 12. Does anyone in your family have a heart problem?   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50?         | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 14. Does anyone in your family have Marfan syndrome?   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 15. Have you ever spent the night in a hospital?   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 16. Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/>                   |

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:								<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:								<input type="checkbox"/>	<input type="checkbox"/>
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:								<input type="checkbox"/>	<input type="checkbox"/>
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest		
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes		

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 20. Have you ever had a stress fracture?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has a doctor ever told you that you have asthma or allergies?                                  | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |

**FEMALES ONLY**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 47. Have you ever had a menstrual period?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 \_\_\_\_\_

# PHYSICAL EXAMINATION

Exam Date: \_\_\_ / \_\_\_ / \_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ PULSE: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_\_ \ \_\_\_\_\_ , \_\_\_\_\_ \ \_\_\_\_\_

VISION: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ CORRECTED: Y N PUPILS: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

MEDICAL	Normal	Abnormal	Explain Abnormal Findings	Initials
Appearance				
Eyes\ears\ nose\throat				
Lymph Nodes				
Heart				
Pulses				
Lungs				
Abdomen				
Genitalia(males)				
Skin				
Other				

ORTHOPEDIC	Normal	Abnormal	Explain Abnormal Findings	Initials
Neck				
Back				
Shoulder / arm				
Elbow / forearm				
Wrist / hand/ fingers				
Hip / thigh				
Knee				
Leg / ankle				
Foot/ toes				
Other				

Comments: \_\_\_\_\_

I certify that, on this date, I have examined the above student as indicated by the items checked above and recommend that the athlete is physically able to participate in supervised athletic activities as checked below:

\_\_\_\_\_ **Cleared without restriction/Full-unlimited participation**

\_\_\_\_\_ Cleared after evaluation / rehabilitation for: \_\_\_\_\_

\_\_\_\_\_ Not Cleared/ No Sport Participation Reason: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_, MD or DO Date: \_\_\_\_\_

**PHYSICIAN STAMP:**