

# 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                       |   | 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"/> | <input type="checkbox"/> |   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Do you have an ongoing or chronic illness?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                                  |                                    |
| 2. Have you ever been hospitalized overnight?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any problems with your eyes or vision?                                       | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses, contacts, or protective eyewear?   | <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"/> | <input type="checkbox"/> | 12. Have you ever had a sprain, strain, or swelling after injury?                             | <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"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints?                              | <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"/> | <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"/>           |
| Have you ever had a rash or hives develop during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <i>If yes, check appropriate box and explain below.</i>                                       |                                  |                                    |
| 5. Have you ever passed out during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head   | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| Have you ever been dizzy during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck   | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| Have you ever had chest pain during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back   | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| Do you get tired more quickly than your friends do during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest  | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/calf |
| Have you ever had racing of your heart or skipped heartbeats?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder   | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| Have you had high blood pressure or high cholesterol?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper arm  |                                  | <input type="checkbox"/> Foot      |
| Have you ever been told you have a heart murmur?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you want to weigh more or less than you do now?  | <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"/> | <input type="checkbox"/> | Do you lose weight regularly to meet weight requirements for your sport?                      | <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"/> | <input type="checkbox"/> | 14. Do you feel stressed out?   | <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"/> | <input type="checkbox"/> | 15. Record the dates of your most recent immunizations (shots) for:                           |                                  |                                    |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____   | Measles _____                    |                                    |
| 7. Have you ever had a head injury or concussion?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B _____   | Chickenpox _____                 |                                    |
| Have you ever been knocked out, become unconscious, or lost your memory?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b> FEMALES ONLY </b>   |                                  |                                    |
| Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 16. When was your first menstrual period? _____   |                                  |                                    |
| Do you have frequent or severe headaches?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? _____   |                                  |                                    |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | How much time do you usually have from the start of one period to the start of another? _____ |                                  |                                    |
| Have you ever had a stinger, burner, or pinched nerve?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? _____   |                                  |                                    |
| 8. Have you ever become ill from exercising in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | What was the longest time between periods in the last year? _____                             |                                  |                                    |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b> Explain "Yes" answers here: </b> _____  |                                  |                                    |
| Do you have asthma?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                                  |                                    |
| Do you have seasonal allergies that require medical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                                  |                                    |

**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 \_\_\_\_\_

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# 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*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
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 or DO