Preparticipation Physical Evaluation

HISTORY

Date of examination _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal physician _____

In case of emergency, contact

Name _____ Relationship _____ Phone (H) _____ (W) _____

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

	Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	❑	❑
2. Have you ever been hospitalized overnight?	❑	❑
Have you ever had surgery?	❑	❑
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 or lose weight or improve your performance?	❑	❑
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	❑	❑
Have you ever had a rash or hives develop during or after exercise?	❑	❑
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 before age 50?	❑	❑
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the past month?	❑	❑
Has a physician ever denied or restricted your participation in sports for any heart problems?	❑	❑
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	❑	❑
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?	❑	❑
8. Have you ever become ill from exercising in the heat?	❑	❑
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?	❑	❑

	Yes	No
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth or hearing aid)?	❑	❑
11. Have you had any problems with your eyes or vision?	❑	❑
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 had any other problems with pain or swelling in muscles, tendons, bones or joints?	❑	❑

❑ Head	❑ Elbow	❑ Thigh
❑ Neck	❑ Forearm	❑ Knee
❑ Back	❑ Wrist	❑ Shin/calf
❑ Chest	❑ Hand	❑ Ankle
❑ Shoulder	❑ Finger	❑ Foot
❑ Upper arm	❑ Hip	

If yes, check appropriate box and explain below.

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?	❑	❑
14. Do you feel stressed out?	❑	❑

15. Record the dates of your most recent immunizations (shots) for:

Tetanus _____ Measles _____

Hepatitis B _____ Chickenpox _____

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 past year? _____

What is the longest time between periods 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

Name _____ Date of birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ Blood pressure _____

	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			
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 _____, M.D. or D.O.