

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		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐	25. Is there anyone in your family who has asthma?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	☐	☐	26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	☐	☐	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐	28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐	29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	30. Have you had a herpes skin infection?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐	31. Have you ever had a head injury or concussion?	☐	☐
9. Has a doctor ever told you that you have (check all that apply):			32. Have you been hit in the head and been confused or lost your memory?	☐	☐
☐ High blood pressure			33. Have you every had a seizure?	☐	☐
☐ A heart murmur			34. Do you have headaches with exercise?	☐	☐
☐ High cholesterol			35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
☐ A heart infection			36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐	37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐	39. Have you had any problems with your eyes or vision?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐	40. Do you wear glasses or contact lenses?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐	41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐	42. Are you happy with your weight?	☐	☐
16. Have you ever had surgery?	☐	☐	43. Are you trying to gain or lose weight?	☐	☐
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:	☐	☐	44. Has anyone recommended you change your weight or eating habits?	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐	45. Do you limit or carefully control what you eat?	☐	☐
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:	☐	☐	46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

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?	☐	☐	FEMALES ONLY	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐	47. Have you ever had a menstrual period?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐	48. How old were you when you had your first menstrual period?	_____	
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐	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 fat (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; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

☐ Up to date (see attached documentation) ☐ Not up to date Specify _____

Name of physician (print/type) _____ Date: _____

Address _____ Phone: _____

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