

# 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 |
| 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"/> |
| <b>FEMALES ONLY</b>                                                                                        |                          |                          |
| 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? _____                                             |                          |                          |
| <b>Explain "Yes" answers here:</b>                                                                         |                          |                          |
| _____                                                                                                      |                          |                          |
| _____                                                                                                      |                          |                          |
| _____                                                                                                      |                          |                          |
| _____                                                                                                      |                          |                          |

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 \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
<b>MUSCULOSKELETAL</b>			
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 \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

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Recommendations: \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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