

# 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? Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>			
2. Have you ever been hospitalized overnight? Have you ever had surgery?	<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? 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"/>			
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?	<input type="checkbox"/>	<input type="checkbox"/>			
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 last month? Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>			
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?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
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?	<input type="checkbox"/>	<input type="checkbox"/>			
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, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>			
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? <i>If yes, check appropriate box and explain below</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper arm	<input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger	<input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Shin/calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot
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?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____					
<b>FEMALES ONLY</b>					
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 last year? _____ What was the longest time between periods in the last 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 \_\_\_\_\_

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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			

\*Stabon -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, DO, PAC, RNP,  
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