

**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.**

- |  |            |           |  |            |           |
|--|------------|-----------|--|------------|-----------|
|  | <b>Yes</b> | <b>No</b> |  | <b>Yes</b> | <b>No</b> |
|--|------------|-----------|--|------------|-----------|
1. Has a doctor ever denied or restricted your participation in sports for any reason?  Yes  No
  2. Do you have an ongoing medical condition (like diabetes or asthma)?  Yes  No
  3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?  Yes  No
  4. Do you have any allergies to medicines, pollens, foods, or stinging insects?  Yes  No
  5. Have you ever passed out or nearly passed out DURING exercise?  Yes  No
  6. Have you ever passed out or nearly passed out AFTER exercise?  Yes  No
  7. Have you ever had discomfort, pain, or pressure in your chest during exercise?  Yes  No
  8. Does your heart race or skip beats during exercise?  Yes  No
  9. Has a doctor ever told you that you have (check all that apply):  
 High blood pressure       A heart murmur  
 High cholesterol       A heart infection
  10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)  Yes  No
  11. Has anyone in your family died for no apparent reason?  Yes  No
  12. Does anyone in your family have a heart problem?  Yes  No
  13. Has any family member or relative died of heart problems or of sudden death before age 50?  Yes  No
  14. Does anyone in your family have Marfan syndrome?  Yes  No
  15. Have you ever spent the night in a hospital?  Yes  No
  16. Have you ever had surgery?  Yes  No
  17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:  Yes  No
  18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:  Yes  No
  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:  Yes  No
  20. Have you ever had a stress fracture?  Yes  No
  21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?  Yes  No
  22. Do you regularly use a brace or assistive device?  Yes  No
  23. Has a doctor ever told you that you have asthma or allergies?  Yes  No
  24. Do you cough, wheeze, or have difficulty breathing during or after exercise?  Yes  No
  25. Is there anyone in your family who has asthma?  Yes  No
  26. Have you ever used an inhaler or taken asthma medicine?  Yes  No
  27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?  Yes  No
  28. Have you had infectious mononucleosis (mono) within the last month?  Yes  No
  29. Do you have any rashes, pressure sores, or other skin problems?  Yes  No
  30. Have you had a herpes skin infection?  Yes  No
  31. Have you ever had a head injury or concussion?  Yes  No
  32. Have you been hit in the head and been confused or lost your memory?  Yes  No
  33. Have you every had a seizure?  Yes  No
  34. Do you have headaches with exercise?  Yes  No
  35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  Yes  No
  36. Have you ever been unable to move your arms or legs after being hit or falling?  Yes  No
  37. When exercising in the heat, do you have severe muscle cramps or become ill?  Yes  No
  38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?  Yes  No
  39. Have you had any problems with your eyes or vision?  Yes  No
  40. Do you wear glasses or contact lenses?  Yes  No
  41. Do you wear protective eyewear, such as goggles or a face shield?  Yes  No
  42. Are you happy with your weight?  Yes  No
  43. Are you trying to gain or lose weight?  Yes  No
  44. Has anyone recommended you change your weight or eating habits?  Yes  No
  45. Do you limit or carefully control what you eat?  Yes  No
  46. Do you have any concerns that you would like to discuss with a doctor?  Yes  No
- |            |            |          |           |       |           |              |           |
|------------|------------|----------|-----------|-------|-----------|--------------|-----------|
| Head       | Neck       | Shoulder | Upper arm | Elbow | Forearm   | Hand/fingers | Chest     |
| Upper back | Lower back | Hip      | Thigh     | Knee  | Calf/shin | Ankle        | Foot/toes |
- FEMALES ONLY**
47. Have you ever had a menstrual period?  Yes  No
  48. How old were you when you had your first menstrual period? \_\_\_\_\_
  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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel safe?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past 30 days, have you had a least 1 drink of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever taken steroid pills or shots without a doctor's prescription?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
9. Questions from the Youth Risk Behavior Survey ( <a href="http://www.cdc.gov/HealthyYouth/yrbs/index.htm">http://www.cdc.gov/HealthyYouth/yrbs/index.htm</a> ) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.	<input type="checkbox"/>	<input type="checkbox"/>

Notes: \_\_\_\_\_

	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 \_\_\_\_\_  Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sports: Fall \_\_\_\_\_ Winter \_\_\_\_\_ Spring \_\_\_\_\_

Date of Initial Examination \_\_\_\_\_

### CLEARANCE

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendation for further evaluation or treatment for: \_\_\_\_\_
- Not cleared  Pending further evaluation
  - For any sports
  - For certain sports \_\_\_\_\_ Reason \_\_\_\_\_

### Recommendations:

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I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and his/her parents/guardian.

Name of physician (print/type) \_\_\_\_\_ MD or DO

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

### EMERGENCY INFORMATION

#### ALLERGIES:

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#### OTHER INFORMATION:

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