Pre-participation Physical Evaluation

History Date of Examination_____

Name_____ Sex_____ Age_____ Date of Birth_____

Grade_____ School _____ Sport(s)_____

Personal physician_____

Name of emergency, contact _____

Relationship_____ Phone (H)_____ (W)_____

Explain "Yes" answers on the reverse side. Circle questions you do not know the answers to.	**Yes**	**No**
1. Have you had a medical illness or injury since you last check up or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
3. Are you currently taking any prescription or non-prescription (over the counter) medication 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 allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
5. Have you every passed out during 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 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?	☐	☐
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 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 an activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
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 keck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
If yes, check box and explain below:	☐	☐

Head	**Chest**	**Elbow**	**Hand**	**Thigh**	**Ankle**
Neck	**Shoulder**	**Forearm**	**Finger**	**Knee**	**Foot**
Back	**Upper Arm**	**Wrist**	**Hip**	**Shin/calf**	**Other:**

13. Do you want or weigh more or less than you do?					☐ ☐
Do you lose weight regularly to meet weight requirements for your sport?					☐ ☐
14. Do you fell stressed out?					☐ ☐
15. Record the dates of your most recent immunizations (shots) for:	**Tetanus**	**Hepatitis B**	**Measles**	**Chickenpox**	

16. <u>FEMALES ONLY</u>

When was you 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?

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

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION

Name: _____ **Date of Birth:** _____

☐ Male ☐ Female Height : _____ Weight: _____

BP: _____ / _____ (_____/ _____) Pulse: _____ Vision: R 20/ _____ L 20/ _____ Vision Corrected: ☐ Yes ☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. [b] Consider GU exam if in private setting. Having third party present is recommended.
[c] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

CLEARANCE

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for : _____

☐ Not cleared

☐ Pending further evaluation ☐ For any sports ☐ For certain sports: _____

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the preparticipation 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 parents/guardians).

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

Address: _____ Phone: _____

Signature of physician: _____, **MD, DO or PA**

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