# Preparticipation Physical Evaluation

**History**

Name:_____ Sex: _____ Age:_____ Date of Birth: _____

Address:_____ Phone:_____

School _____ Grade:_____ Sport:_____

| **Explain "Yes" answers below:** | **Yes** | **No** |
|---|---|---|
| 1. Have you ever been hospitalized? | ☐ | ☐ |
| Have you ever had surgery? | ☐ | ☐ |
| 2. Are you presently taking any medications or pills? | ☐ | ☐ |
| 3. Do you have any allergies (medicine, bees or other stinging insects)? | ☐ | ☐ |
| 4. 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 tire more quickly than your friends during exercise? | ☐ | ☐ |
| Have you ever had high blood pressure? | ☐ | ☐ |
| Have you ever been told that you have a heart murmur? | ☐ | ☐ |
| Have you ever had racing of your heart or skipped heartbeats? | ☐ | ☐ |
| Has anyone in your family died of heart problems or a sudden death before age 50? | ☐ | ☐ |
| 5. Do you have any skin problems (itching, rashes, acne)? | ☐ | ☐ |
| 6. Have you ever had a head injury? | ☐ | ☐ |
| Have you ever been knocked out or unconscious? | ☐ | ☐ |
| Have you ever had a seizure? | ☐ | ☐ |
| Have you ever had a stinger, burner or pinched nerve? | ☐ | ☐ |
| 7. Have you ever had heat or muscle cramps? | ☐ | ☐ |
| Have you ever been dizzy or passed out in the heat? | ☐ | ☐ |
| 8. Do you have trouble breathing or do you cough during or after activity? | ☐ | ☐ |
| 9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? | ☐ | ☐ |
| 10. Have you had any problems with your eyes or vision? | ☐ | ☐ |
| Do you wear glasses or contacts or protective eye wear? | ☐ | ☐ |
| 11. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? | ☐ | ☐ |
| 12. Have you had a medical problem or injury since your last evaluation? | ☐ | ☐ |
| 13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints | ☐ | ☐ |

☐ Head ☐ Back ☐ Shoulder ☐ Forearm ☐ Hand ☐ Hip ☐ Knee ☐ Ankle
☐ Neck ☐ Chest ☐ Elbow ☐ Wrist ☐ Finger ☐ Thigh ☐ Shin ☐ Foot

14. When was your first menstrual period?_____
When was your last menstrual period? _____
What was the longest time between your periods last year? _____

**Explain "Yes" answers:**

_____
_____
_____
_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Date: _____

Signature of Athlete:_____

Signature of Parent/Guardian _____

## Physical Examination

| | | | | |
|---|---|---|---|---|
| COMPLETE | LIMITED | Height:_____ Weight_____ BP:___/_____ Pulse:_____<br>Vision R 20/ _ L 20/ __ Corrected Y N | | |
| | | | Normal | Abnormal Findings |
| | | Cardiovascular | | |
| | | Pulses | | |
| | | Heart | | |
| | | Lungs | | |
| | | Skin | | |
| | | E.N.T. | | |
| | | Abdominal | | |
| | | Genitalia (Males) | | |
| | | Musculosketetal | | |
| | | Neck | | |
| | | Shoulder | | |
| | | Elbow | | |
| | | Wrist | | |
| | | Hand | | |
| | | Back | | |
| | | Knee | | |
| | | Ankle | | |
| | | Foot | | |
| | | Other | | |

Clearance:

A. Cleared
B. Cleared after completing evaluation/rehabilitation for :_____
C. Not Cleared for: ☐ Collision
☐ Contact
☐ Noncontact ____Strenuous ____Moderately Strenuous ____Nonstrenuous

Due to:_____

Recommendation: _____

_____

_____

Name of Physician: _____ Date: _____

Address:_____ Phone: _____

Signature of Physician: _____ M.D. or D.O.