

Pre-Participation Physical Evaluation

(Complete side 1 only prior to coming for physical)

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: _____ W: _____

Explain "Yes" answers below.
Circle questions you don't know the answers to.

		YES	NO			YES	NO
Have you had a medical illness or injury since your last check up or sports physical?				Do you use any special 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)?			
Have you ever been hospitalized overnight?				Have you had any problems with your eyes or vision?			
Have you ever had surgery?				Do you wear glasses, contacts, or protective eyewear?			
Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?				Have you ever had a sprain, strain, or swelling after injury?			
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?				Have you broken or fractured any bones or dislocated any joints?			
Do you have any allergies (for example, pollen, medicine, food, or stinging insects)?				Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?			
Have you ever had a rash or hives develop during or after exercise?				If yes, check appropriate box and explain below.			
Have you ever passed out during or after exercise?				__ Head __ Elbow __ Hip			
Have you ever been dizzy during or after exercise?				__ Neck __ Forearm __ Thigh			
Have you ever had chest pain during or after exercise?				__ Back __ Wrist __ Knee			
Do you get tired more quickly than your friends do during exercise?				__ Chest __ Hand __ Shin/Calf			
Have you ever had racing of your heart or skipped heartbeats?				__ Shoulder __ Finger __ Ankle			
Have you had high blood pressure or high cholesterol?				__ Upper arms __ Foot			
Have you ever been told you have a heart murmur?				Do you want to weigh more or less than you do now?			
Has any family member or relative died of heart problems or of sudden death before age 50?				Do you lose weight regularly to meet weight requirements for your sport?			
Have you had a severe viral infection (for example, myocardia or mononucleosis) within the last month?				Do you feel stressed out?			
Has a physician ever denied or restricted your participation in sports for any heart problems?				Record the dates of your most recent immunizations (shots) for:			
Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blister)?				Tetanus: _____ Measles: _____			
Have you ever had head injury or concussion?				Hepatitis B: _____ Chickenpox: _____			
Have you ever been knocked out, become unconscious, or lost your memory?				FEMALES ONLY			
Have you ever had a seizure?				When was your first menstrual period? _____			
Do you have frequent or severe headaches?				When was your most recent menstrual period? _____			
Have you ever had numbness or tingling in your arms, hands, legs, or feet?				How much time do you usually have from the start of one period to the start of another? _____			
Have you ever had a stinger, burner, or pinched nerve?				How many periods have you had in the last year? _____			
Have you ever become ill from exercising in the heat?				What was the longest time between periods in the last year? _____			
Do you cough, wheeze, or have trouble breathing during or after activity?				Explain "Yes" answers here: _____			
Do you have asthma?				_____			
Do you have seasonal allergies that require medical treatment?				_____			

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: _____

****I give permission for _____ (athlete), to complete the Preparticipation Physical Evaluation.
 Parent/Guardian signature: _____ Date: _____

Pre-Participation Physical Evaluation

(To be completed at time of physical)

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
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station 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: _____ M.D. or D.O.