

Pre-participation Physical Evaluation

Athlete's Name _____

Home address _____

Father's Name _____

Mother's Name _____

Personal Physician _____ Phone _____

Home Phone _____

City/State _____

Cell Phone _____

Cell Phone _____

Health Insurance _____

Grade (11-12 school year) _____

Zip _____

Work Phone _____

Work Phone _____

Phone _____

HISTORY SECTION

Explain "Yes" answers below. Circle questions you do not 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? | () | () | 8. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | () | () |
| Do you have an ongoing or chronic illness? | () | () | Have you ever had a stinger, burner or pinched nerve? | () | () |
| 2. Have you ever been hospitalized overnight? | () | () | 9. Have you ever become ill from exercising in the heat? | () | () |
| Have you ever had surgery? | () | () | 10. Do you cough, wheeze, or have trouble breathing during or after an activity? | () | () |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? List below. | () | () | Do you suffer from asthma? | () | () |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | () | () | Do you have seasonal allergies that require medical treatment? | () | () |
| 4. Do you have any food allergies (for example, to pollen, medicine, food, or stinging insects)? List below. | () | () | 11. Do you use any protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck rolls, foot orthotics, retainer on your teeth, hearing aids)? | () | () |
| Have you ever had a rash or hives develop during or after exercise? | () | () | 12. Have you had any problems with your eyes or vision? | () | () |
| 5. Have you ever passed out during or after exercise? | () | () | Do you wear glasses, contacts, or protective eyewear? | () | () |
| Have you ever been dizzy during or after exercise? | () | () | 13. Have you ever had a sprain, strain, or swelling after injury? | () | () |
| Have you ever had chest pains during or after exercise? | () | () | Have you broken or fractured any bones or dislocated any joints? | () | () |
| Do you get tired more quickly than your friends do during exercise? | () | () | Have you had any problems with pain or swelling in muscles, tendons, bones, or joints? | () | () |
| Have you ever had racing of your heart or skipped heartbeats? | () | () | <i>If yes, check appropriate boxes and explain below.</i> | | |
| Have you had high blood pressure or high cholesterol? | () | () | Head () | Elbow () | Hip () |
| Have you ever been told you have a heart murmur? | () | () | Neck () | Forearm () | Thigh () |
| Has any family member or relative died of heart problems or sudden death before age 50? | () | () | Back () | Wrist () | Knee () |
| Have you ever had severe viral infection (for example, myocarditis or mononucleosis) within the last month? | () | () | Chest () | Hand () | Shin/Calf () |
| Has your physician ever denied or restricted your participation in sports for any heart problems? | () | () | Shoulder () | Finger () | Ankle () |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | () | () | Upper Arm () | Foot () | |
| 7. Have you had a head injury or concussion? | () | () | 14. Do you want to weigh more or less than you do now? | () | () |
| Have you ever been knocked out, become unconscious, or lost your memory? | () | () | Do you lose weight regularly to meet the requirements of your sport? | () | () |
| Have you ever had a seizure? | () | () | 15. Do you feel stressed out? | () | () |
| Do you have frequent or severe headaches? | () | () | FEMALES ONLY | | |
| | | | 16. 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? _____ | | |

Explain "Yes" answers here: _____

List medications you are currently taking _____

Allergies _____

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

Signature of athlete _____ Signature of parent/guardian _____ Date of signatures _____

Pre-participation Physical Evaluation

Athlete's Name _____

Date of Birth _____

Grade (11-12 school year) _____

Height _____

Weight _____

Pulse _____

Blood Pressure _____ / _____

MEDICAL

	Normal	Abnormal Findings
Appearance		
Eyes/Ears/ Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		

MUSCULOSKELETAL

	Normal	Abnormal Findings
Neck		
Back		
Shoulder/ Arms		
Elbow/ Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Doctor Signature - Medical Exam _____ Date _____

Doctor Signature - Musculoskeletal Exam _____ Date _____

Clearance

() Cleared

() Cleared after completing evaluation/rehabilitation for: _____

() Not cleared for: _____ Reason: _____

Recommendations: _____

Name of physician (print or type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO