

# Preparticipation Physical Evaluation

**HISTORY FORM**

DATE OF EXAM \_\_\_\_\_

Name _____	Sex _____	Age _____	Date of birth _____
Grade _____	School _____	Sport(s) _____	
Address _____		Phone _____	
Personal physician _____			
<i>In case of emergency, contact:</i>			
Name _____	Relationship _____	Phone (H) _____	(W) _____

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

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure			33. Have you every had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol			34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart murmur			35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart infection			36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

  

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

  

20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>

  

**FEMALES ONLY**

47. Have you ever had a menstrual period?

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 <small>(males only)*</small>			
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