



Preparticipation Physical Evaluation

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 (H) _____	(W) _____

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

- | | Yes | No |
|--|--------------------------|--|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <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"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | |
| <input type="checkbox"/> High blood pressure | | <input type="checkbox"/> A heart murmur |
| <input type="checkbox"/> High cholesterol | | <input type="checkbox"/> A heart infection |
| 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <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"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine? | <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"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | <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"/> |
| 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"/> |
| 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses? | <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"/> |
| 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat? | <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"/> |

FEMALES ONLY

47. Have you ever had a menstrual period? Yes No
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: _____

17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:
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:

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"/> |
| 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"/> |
| 22. Do you regularly use a brace or assistive device? | <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"/> |
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

- | | | |
|--|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure? | Yes | No |
| | <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 at 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"/> |

Notes:

	NORMAL	ABNORMAL FINDINGS	INITIALS *
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)* *			
Skin			
MUSCULOSKELETAL			
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:

Sports participation: Approved: _____ Conditional: _____ Denied: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD, DO, ND, NP or PA