

Preparticipation Physical Evaluation

HISTORY FORM

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? Yes No
 2. Do you have an ongoing medical condition (like diabetes or asthma)? Yes No
 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Yes No
 4. Do you have allergies to medicines, pollens, foods, or stinging insects? Yes No
 5. Have you ever passed out or nearly passed out DURING exercise? Yes No
 6. Have you ever passed out or nearly passed out AFTER exercise? Yes No
 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? Yes No
 8. Does your heart race or skip beats during exercise? Yes No
 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) Yes No
 11. Has anyone in your family died for no apparent reason? Yes No
 12. Does anyone in your family have a heart problem? Yes No
 13. Has any family member or relative died of heart problems or of sudden death before age 50? Yes No
 14. Does anyone in your family have Marfan syndrome? Yes No
 15. Have you ever spent the night in a hospital? Yes No
 16. Have you ever had surgery? Yes No

| | |
|---|--|
| 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: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 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"/> Yes <input type="checkbox"/> No |

| | | | | | | | |
|------------|------------|----------|-----------|-------|-----------|--------------|-----------|
| 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? Yes No
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No
22. Do you regularly use a brace or assistive device? Yes No
23. Has a doctor ever told you that you have asthma or allergies? Yes No

- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No
 25. Is there anyone in your family who has asthma? Yes No
 26. Have you ever used an inhaler or taken asthma medicine? Yes No
 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Yes No
 28. Have you had infectious mononucleosis (mono) within the last month? Yes No
 29. Do you have any rashes, pressure sores, or other skin problems? Yes No
 30. Have you had a herpes skin infection? Yes No
 31. Have you ever had a head injury or concussion? Yes No
 32. Have you been hit in the head and been confused or lost your memory? Yes No
 33. Have you ever had a seizure? Yes No
 34. Do you have headaches with exercise? Yes No
 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No
 36. Have you ever been unable to move your arms or legs after being hit or falling? Yes No
 37. When exercising in the heat, do you have severe muscle cramps or become ill? Yes No
 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Yes No
 39. Have you had any problems with your eyes or vision? Yes No
 40. Do you wear glasses or contact lenses? Yes No
 41. Do you wear protective eyewear, such as goggles or a face shield? Yes No
 42. Are you happy with your weight? Yes No
 43. Are you trying to gain or lose weight? Yes No
 44. Has anyone recommended you change your weight or eating habits? Yes No
 45. Do you limit or carefully control what you eat? Yes No
 46. Do you have any concerns that you would like to discuss with a doctor? Yes No

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: _____

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

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

| Yes | No |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <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: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO