Preparticipation Physical Evaluation

Revised 7/1/05
Mandatory

Date of Exam ___________________________

HISTORY FORM

Name ____ Sex ______ Age ______ Date of birth _________________

Grade _____ School ____ Sport (s) ____

Address ____ Phone _________________________

Personal Physician ____

In case of emergency, contact:

Name ____ Relationship ________ Phone (H) __________ Phone (W) ____________

Explain "Yes" answers below.
Circle questions if you do not know the answers.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3.	Are you currently taking any prescription or non-prescription (over the counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
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:	☐	☐
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

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

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Preparticipation Physical Evaluation

PHYSICAL EXAMINATION DATE OF EXAM ______________________

This page to be completed by physician/nurse practitioner/physician assistant.

Name ____ Date of Birth ______________________

Height _______ Weight _______ % Body Fat (optional) _______ Pulse _______ BP _______________

Vision R 20 / ______ L 20/______ Corrected? Y N Pupils - Equal ____ Unequal ____ Hearing ____

	NORMAL	ABNORMAL FINDING	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:

____
____
____
____

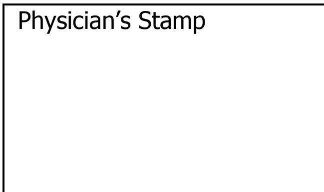
☐ Not cleared for [Sport(s)]: ____________ Reason: ____

Recommendation: ____
____
____

Name of physician/nurse practitioner/physician assistant (print/type) _________________________ Date ________

Address: ____ Telephone ________________

Signature of physician/nurse practitioner/physician assistant: ______________________________________
MD/nurse practitioner/physician assistant


Physician's Stamp

PARTICIPATION PHYSICAL EVALUATION (MONOGRAPH). KANSAS CITY, MO: AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN MEDICAL SOCIETY FOR SPORTS MEDICINE, AMERICAN ORTHOPAEDIC SOCIETY FOR SPORTS MEDICINE, AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE, 1992, 1996

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