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)_____

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___
2. Have you ever been hospitalized overnight?	___	___
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills, or using an inhaler?	___	___
4. Do you have any allergies (i.e. to pollen, medicine, food, or stinging insects)?	___	___
5.**Have you ever passed out during or after exercise?**	___	___
6.**Have you ever been dizzy during or after exercise?**	___	___
7.Have you ever had chest pain during or after exercise?	___	___
8.Do you get tired more quickly than your friends do during exercise?	___	___
9.Have you ever had racing of your heart or skipped heartbeats?	___	___
10.Have you had high blood pressure or high cholesterol?	___	___
11.Have you ever been told you have a heart murmur?	___	___
12.Has any family member or relative died of heart problems or of sudden death before age 50?	___	___
13.Have you had a severe viral infection (i.e myocarditis or mononucleosis) within the last month?	___	___
14.Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___
15.Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, or blisters)?	___	___
16.Have you ever had a head injury or concussion?	___	___
17.Have you ever been knocked out, become unconscious, or lost your memory?	___	___
18. Have you ever had a seizure?	___	___
19.Do you have frequent or severe headaches?	___	___
20.Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___
21.Have you ever had a stinger, burner or pinched nerve?	___	___
22. Have you ever become ill from exercising in the heat?	___	___
23. Do you cough, wheeze or have trouble breathing during or after activity?	___	___
24.Do you have asthma?	___	___
25.Do you have seasonal allergies that require medical treatment?	___	___

	Yes	No
26. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	___	___
27. Have you had any problems with your eyes or vision?	___	___
28. Have you ever had a sprain, strain, or swelling after injury?	___	___
29.Have you broken or fractured any bones or dislocated any joints?	___	___
30.Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below:	___	___

___ Head	___Elbow	___Hip
___Neck	___Forearm	___Thigh
___Back	___Wrist	___Knee
___Chest	___Hand	___Shin/calf
___Shoulder	___Finger	___Ankle
___Upper arm	___Foot	

31. Do you want to weigh more or less than you do now?	___	___
32. Do you feel stressed out?	___	___

33. Record the dates of your most recent immunizations (shots) for:
Tetanus_____ Measles_____
Hepatitis B_____ Chickenpox_____

FEMALES ONLY
34. When was your first menstrual period? _____
35. When was your most recent menstrual period? _____
36.How much time do you usually have from the start of one period to the start of another?_____
37.How many periods have you had in the last year?_____
38.What was the longest time between periods in the last year?_____

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

Name_____Date of Birth_____

Height_____Weight_____%Body fat (optional)_____Pulse_____BP_____/_____(_____/_____,_____/_____)

Vision R 20/	L 20/	Corrected: Y N Pupils Equal Unequal	
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS***
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			

_____ Cleared

_____Cleared after completing evaluation/rehabilitation for:_____

_____

_____

_____

_____**Not cleared for**:_____ Reason: _____

Recommendations:_____

_____

_____

_____

Name of Physician (Print/Type)_____Date_____

Address_____Phone_____

Signature of Physician _____ MD ; DO; DC

Physician's Stamp: