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 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 of 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	

	Yes	No
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 answer 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			
Hear			
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: