

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) _____ Phone (W) _____

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

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):
☐ 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) ☐ 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: ☐ Yes ☐ No
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: ☐ Yes ☐ 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: ☐ Yes ☐ 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

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 _____

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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 _____

	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

Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

- ☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for: _____

☐ Not Cleared for ☐ All sports ☐ Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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