## **Preparticipation Physical Evaluation**

**HISTORY FORM** 

Sport(s)  Sport(s)  Phone  Sport(s)  Phone  Sport(s)  Phone  Sport(s)  Phone  Sport(s)  Phone  Relationship  Phone (H)  Phone(W)  Sport(s)  In a sport or any reason?  In a sport (so any	lame								_Sex	<age< th=""><th>Date of birth</th><th></th></age<>	Date of birth	
ersonal Physician	rade_	S	chool						Sp	ort(s)		
Phone (H)	ddres	ss									Phone	
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? 2. Do you have an ongoing medical condition (like diabetes or asthman? 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? 5. Is there anyone in your family who has asthma? 27. Were you born without or are you missal participation in sports for any reason? 28. Have you ever used an inhalter or taken asthma medicine? 27. Were you born without or are you missal participation or nonprescription (over-the-counter) medicines or pills? 28. Have you were used an inhalter or taken asthma medicine? 29. Do you have very passed out or nearly passed out DURING exercise? 30. Have you than disclosum sonnouncleosis (mono) within the last month? 31. Have you had a herpes skin infection? 32. Have you ever had a head injury or concussion? 33. Have you ever had a head and been confused or lost your memory? 34. Have you ever had a seizure? 35. Have you ever had a seizure? 36. Have you ever had a seizure? 37. Have you ever had a seizure? 38. Have you ever had a seizure? 39. Have you ever had a seizure? 30. Have you ever had a seizure? 30. Have you ever had seizure? 30. Have you ever had seizure? 31. Have you ever had seizure? 32. Have you ever had seizure? 33. Have you ever had seizure? 34. Do you have serve seen the night no falling? 35. Have you ever had a seizure? 36. Have you ever had seizure? 37. When exercise? 38. Have you ever had a seizure? 39. Have you ever had seizure? 39. Have you ever had seizure? 30. Have you ever had seizure? 30. Have you ever had seizure? 30. Have you ever had an problem? 31. Have you ever had an problem? 32. Have you ever had an problem? 33. Have you ever had an problem? 34. Do you have serve spent the night in a hespital? 35. Have you ever had seizure? 36. Have you ever had seizure? 37. When exerciseing in the heat, do you have severe muscle cramps or become ill? 38. Have you ever had	erson	al Phys	ician									
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?  2. Do you have an ongoing medical condition (like diabetes or asthman)?  3. Are you currently taking any prescription or nonprescription (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):	cas	e of em	ergenc	y, cont	act:							
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(like diabetes or asthma)?  3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?  4. Do you have allergies to medicines, pollens, foods, or stinging inseast?  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 passed out or nearly passed out AFTER 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):  10. Has a doctor ever told you that you have (check all that apply):  11. Has anyone in your family have a heart problem?  13. Has any family member or relative died of heart problems or of sudden death before age 50?  14. Does anyone in your family have a heart problem?  15. Have you ever had a ministection?  16. Have you ever bean unable to move 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 head, do you have severe muscle camps or becewer, such as of contact lenses?  40. Do you have any family have were had a ninfection or six diden death before age 50?  41. Does anyone in your family have heart problem?  41. Have you ever been unable to move your arms or legs after being hit or falling?  42. Have you ever been unable to move your arms or legs after being hit or falling?  43. Has a doctor over ordered a test for your heart?  44. Do you have heard an implify in a hospital?  45. Have you ever been unable to move your arms or legs after being hit or falling?  46. Do you wear protective or sickle cell disease?  47. Have you ever had an inight in a hospital?  48. Has a doctor told you that you do you have severe muscle company.  49. How one very bean the inight in a hospital?  40. Do you wear protective or sickle cell disease?  41. Do you wear protective or sickle cell disease?  42. Are you had any broken or fractured bones or dislocated joints? If yes, circle below:  43. Has a go	in :	sports for	any reas	on?		, ,				during or after exe	rcise?	
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High cholesterol										35. Have you ever had	d numbness, tingling, or weakness	
10. Has a doctor ever ordered a test for your heart?   (for example: ECG, echocardiogram)				re	A h	eart murmui eart infectio	n					
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 of 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 tendinitis, 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:  19. Have you ever had a stress fracture? 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 told you that you or someone in your family has a slocke call trait or sickle cell disease? 38. Has a adoctor told you that you to someone in your family have sickle cell trait or 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 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? 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:  Explain "Yes" answers here:		, .		dered a te	st for yo	ur heart?						
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family has sickle cell trait or sickle cell disease?  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 glasses or contact lenses?  41. Do you wear protective eyewear, such as goggles or a face shield?  42. Are you 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:  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:  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?  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:  Explain "Yes" answers here:		-	•	-			son?	H	H			
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Back Back Shin Toes  49. How many periods have you had in the last 12 months?  Explain "Yes" answers here:  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				Arm			Fingers					od?
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			пір	rnign	Knee	1	Ankie			49. How many periods	have you had in the last 12 months?_	
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		-								Explain "Yes" answe	rs here:	
22. Do you regularly use a brace or assistive device?  23. Has a doctor ever told you that you have asthma		-		-		•						
	22. Do	you regu	ularly use	a brace o	or assisti	ve device?						
				d you tha	t you hav	e asthma						

## **Preparticipation Physical Evaluation**

## PHYSICAL EXAMINATION FORM

Name				Date of Birth					
Height	Weight	% Body	Fat (optional)	Pulse	BP	/	_(/_		
Vision R 20/	L 20/_	Corre	cted: Y N	Pupils: Eq	ual	_ Uneq	ual	-	
		NORMAL	AE	BNORMAL FINDI	NGS			INITIALS*	
MEDICAL									
Appearance									
Eyes/ears/nose/	throat								
Hearing									
Lymph nodes									
Heart									
Murmurs									
Pulses									
Lungs									
Abdomen									
Genitourinary (m	nales only)+								
Skin									
MUSCULOSK	ELETAL								
Neck									
Back									
Shoulder/arm									
Elbow/forearm									
Wrist/hand/finge	ers								
Hip/thigh									
Knee									
Leg/ankle									
Foot/toes									
*Multiple-examiner set-u +Having a third party pre		d for the genitourinary ex	amination.					·	
Notes:									
Name of physic	ian (print/type	)					Date		
Address						Ph	one		
Signature of phy	/sician							MD or DO	

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## **Preparticipation Physical Evaluation**

**CLEARANCE FORM** 

Nam	ne	Sex	Age	Date of birth	
	Cleared without restriction Cleared, with recommendations for furth	her evaluation or tro	eatment for:		
	Not Cleared for  All sports  Cer	tain sports:		Reason	:
Rec	ommendations:				
EME	ERGENCY INFORMATION				
Allei	rgies				
Othe	er Information				
Nam	ne of physician (print/type)				Date
Add	ress			Phone _	
Sign	nature of physician				, MD or DO
repa	articipation Physical Evaluation				CLEARANCE FORM
Nam	ne	Sex	Age	Date of birth_	
	Cleared without restriction Cleared, with recommendations for furth	her evaluation or tro	eatment for:		
□ Rec	Not Cleared for  All sports  Cerommendations:	tain sports:		Reason	:
EME	ERGENCY INFORMATION				
Allei	rgies				
Othe	er Information				
Nan	ne of physician (print/type)				Date
Add	ress			Phone _	

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Osteopathic Academy of Sports Medicine.