

PREPARTICIPATION PHYSICAL FORM

DATE OF EXAM: ____/____/____

HISTORY

Name: _____ Sex: Male, Female Age: _____ Date of birth: ____/____/____

Grade: _____ School: _____ Sport(s): _____

Address: _____ Phone: _____

Personal physician: _____

In case of emergency, contact

Name: _____ Relationship: _____ Phone (H): _____ (W) : _____

Explain "Yes" answers below.

Circle questions you don't know the answers to

| | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken any supplements/vitamins to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check appropriate box and explain below. | | |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip | | |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh | | |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee | | |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/calf | | |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle | | |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper arm <input type="checkbox"/> Foot | | |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Record the year of your most recent immunizations (shots) for: (if unknown put ? in space) | | |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus: _____ Measles: _____ | | |
| 7. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B: _____ Chickenpox: _____ | | |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES ONLY | XXXXXXXX | |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | 16. When was your first menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> | How much time do you usually have from the start of one period to the start of another? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | What was the longest time between periods in the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> | Explain "Yes" answers here: _____ | | |
| Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| | | | _____ | | |
| | | | _____ | | |
| | | | _____ | | |
| | | | _____ | | |

Signature of athlete: _____ Signature of parent/guardian: _____ Date: _____

SPORTS PREPARTICIPATION PHYSICAL EXAM

Name: _____ Date of birth: _____
 Height: _____ Weight: _____ % Body fat (optional): _____ Pulse: _____ BP ____/____ (____/____, ____/____)
 Vision R 20/____ L 20/____ Corrected: YES NO Pupils: Equal Unequal

PHYSICAL EXAM

| | NORMAL | SKIPPED | ABNORMAL FINDINGS | INITIALS* |
|------------------------|--------------------------|--------------------------|-------------------|-----------|
| MEDICAL | | | | |
| Appearance | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Eyes/Ears/Nose/Throat | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Lymph Nodes | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Heart | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Pulses | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Lungs | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Abdomen | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Genitalia (males only) | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Skin | <input type="checkbox"/> | <input type="checkbox"/> | | |
| MUSCULOSKELETAL | | | | |
| Neck | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Back | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Shoulder/arm | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Elbow/forearm | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Wrist/hand | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Hip/thigh | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Knee | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Leg/ankle | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Foot | <input type="checkbox"/> | <input type="checkbox"/> | | |

* Station-based examination only

CLEARANCE

- Cleared for unrestricted participate / play.
 Cleared after completing evaluation/rehabilitation for: _____

- Not cleared for: _____ Reason: _____

Recommendations: _____

Signature of physician _____