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) ______

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Explain “Yes” answers below. Circle questions you don’t know the answers to.

Yes No

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 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 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 high blood pressure? ______

10. Has a doctor ever ordered a test for your heart? (for example, EKG, echocardiogram) ______

11. Has anyone in your family died of no apparent reason? ______

12. Does anyone in your family have a heart problem? ______

13. Has anyone 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 strain, 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: ______

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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? ______

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 or allergies? ______

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24. Do you cough, wheeze, or have difficulty breathing with 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? ______

28. Have you had infectious mononucleosis (mono) within the last month? ______

29. Have you had any rashes, pressure sores, or other skin problems? ______

30. Have you had a herpes skin infection? ______

31. Have you ever had a head injury or concussion? ______

32. Have you been hit in the head and been confused or lost your memory? ______

33. Have you ever had a seizure? ______

34. Do you have headaches with exercise? ______

35. Have you ever had numbness, tingling, or weakness in 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 is the heat, do you have severe muscle cramps or become ill? ______

38. Has a doctor told you that you or someone in your 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 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? ______

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**FEMALES ONLY**

47. Have you ever had a menstrual period? ______

48. How old were you when you had your first menstrual period? ______

49. How many periods have you had in the last year? ______

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Explain “Yes” answers here:

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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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# 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 _____

## Follow-Up Questions on More Sensitive Issues

1. Do you feel stressed out or under a lot of pressure? [ ] Yes [ ] No
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? [ ] Yes [ ] No
3. Do you feel safe? [ ] Yes [ ] No
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? [ ] Yes [ ] No
5. During the past 30 days, did you use chewing tobacco, snuff, or dip? [ ] Yes [ ] No
6. During the past 30 days, have you had at least 1 drink of alcohol? [ ] Yes [ ] No
7. Have you ever taken any medications or drugs that alter your behavior or affect your mood? [ ] Yes [ ] No
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance? [ ] Yes [ ] No
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc [ ] Yes [ ] No

Notes:

## Medical Examination

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<th>Abnormal Findings</th>
<th>Initials*</th>
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<tr>
<td>Appearance</td>
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<tr>
<td>Eyes/ears/nose/throat</td>
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<tr>
<td>Hearing</td>
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<td>Lymph nodes</td>
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<td>Heart</td>
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<td>Lungs</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Genitourinary†</td>
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<tr>
<td>Skin</td>
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</tbody>
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## Musculoskeletal Examination

<table>
<thead>
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<th>Musculoskeletal Examination</th>
<th>Normal</th>
<th>Abnormal Findings</th>
<th>Initials*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
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<tr>
<td>Back</td>
<td></td>
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<td></td>
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<tr>
<td>Shoulder/arm</td>
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<tr>
<td>Elbow/forearm</td>
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<tr>
<td>Wrist/hand/fingers</td>
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<td></td>
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<tr>
<td>Hip/thigh</td>
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<tr>
<td>Knee</td>
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<tr>
<td>Leg/ankle</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Foot/toes</td>
<td></td>
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</tbody>
</table>

*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 ___________________________


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Preparticipation Physical Evaluation

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: ____________________________

Recommenations: ____________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

EMERGENCY INFORMATION

Allergies ____________________________

Other Information ____________________________

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

☐ Up to date (see attached documentation) ☐ Not up to date Specify ____________________________

Name of physician (print/type) ____________________________ Date ____________

Address ____________________________ Phone ____________________________

Signature of physician ____________________________, MD or DO

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Name of physician (print/type) ____________________________ Date ____________

Address ____________________________ Phone ____________________________

Signature of physician ____________________________, MD or DO


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