Pre-Participation Physical Evaluation

Health History

Date of Exam_____

Name_____ Age_____ Sex_____ Date of Birth_____

Grade_____ School_____ Sport(s)_____

Address_____ City_____ State_____ 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

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical?	☐	☐
• Do you have an on-going or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
• Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	☐	☐
• Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	☐	☐
• Have you ever had a rash or hives develop during or after execise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
• Have you ever been dizzy during or after exercise?	☐	☐
• Have you ever had chest pain during or after exercise?	☐	☐
• Do you get tired more quickly than your friends do during exercise?	☐	☐
• Have you ever had racing of your heart or skipped heartbeats?	☐	☐
• Have you had high blood pressure or high cholesterol?	☐	☐
• Have you ever been told you have a heart murmur?	☐	☐
• Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
• Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
• Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
• Have you ever been knocked out, become unconcious, or lost your memory?	☐	☐
• Have you ever had a seizure?	☐	☐
• Do you have frequent or severe headaches?	☐	☐
• Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
• Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity	☐	☐
• Do you have asthma?	☐	☐
• Do you have seasonal allergies that require medical treatment?	☐	☐

	Yes	No
10. Do you have any special or corrective equipment or devices that aren't usually used for your sport or position (examples: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid, etc.)	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
• Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain or swelling after injury?	☐	☐
• Have you broken or fractured any bones or dislocated any joints?	☐	☐
• 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
☐Chest	☐Wrist	☐Knee
☐Shoulder	☐Hand	☐Shin/calf
☐Upper Arm	☐Finger	☐Ankle
		☐Foot

13. Do you want to weigh more or less than you do now?	☐	☐
• Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14. Do you feel stressed out?	☐	☐

15. Record the dates of your most recent immunizations:
Tetanus_____ Measles_____
Hepatitis B_____ Chickenpox_____

FEMALES ONLY

16. When was your first menstrual period?_____
When was your most recent menstrual period?_____
How much time do you usually have from the start of one period to the start of another?_____
How many periods have you had in the last year?_____
What was the longest time between periods in the last year?_____

EXPLAIN ANY 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 Student_____ Signature of Parent_____ Date_____

Pre-Participation Physical Evaluation

Physical Examination

Name_____ Date of Birth_____

Height_____ Weight_____ % Body Fat (Optional)_____ Pulse_____ BP_____/_____ (_____/_____)

Vision R 20/_____ L 20/_____ Corected Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Stabon-based examination only

CLEARANCE

☐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,PAC,RNP,DC