## Preparticipation Physical Evaluation

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

### Date of Exam

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Medicines and Allergies

Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>Pollens</td>
</tr>
<tr>
<td>Stinging Insects</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**Do you have any allergies?**

- [ ] Yes
- [ ] No

If yes, please identify specific allergy below.

- [ ] Medicines
- [ ] Pollens
- [ ] Food

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

### GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason?  
   - [ ] Yes
   - [ ] No

2. Do you have any ongoing medical conditions? If so, please identify below:  
   - [ ] Asthma
   - [ ] Anemia
   - [ ] Diabetes
   - [ ] Infections
   - [ ] Other:

3. Have you ever spent the night in the hospital?  
   - [ ] Yes
   - [ ] No

4. Have you ever had surgery?  
   - [ ] Yes
   - [ ] No

### HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out DURING or AFTER exercise?  
   - [ ] Yes
   - [ ] No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?  
   - [ ] Yes
   - [ ] No

7. Does your heart ever race or skip beats (irregular beats) during exercise?  
   - [ ] Yes
   - [ ] No

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:  
   - [ ] High blood pressure
   - [ ] A heart murmur
   - [ ] High cholesterol
   - [ ] A heart infection
   - [ ] Kawasaki disease
   - [ ] Other:

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)  
   - [ ] Yes
   - [ ] No

10. Do you get lightheaded or feel more short of breath than expected during exercise?  
    - [ ] Yes
    - [ ] No

11. Have you ever had an unexplained seizure?  
    - [ ] Yes
    - [ ] No

12. Do you get more tired or short of breath more quickly than your friends during exercise?  
    - [ ] Yes
    - [ ] No

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

13. Has any family member or relative died of heart problems or had an unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?  
    - [ ] Yes
    - [ ] No

14. Does anyone in your family have a heart murmur?  
    - [ ] Yes
    - [ ] No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?  
    - [ ] Yes
    - [ ] No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  
    - [ ] Yes
    - [ ] No

### BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?  
    - [ ] Yes
    - [ ] No

18. Have you ever had any broken or fractured bones or dislocated joints?  
    - [ ] Yes
    - [ ] No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?  
    - [ ] Yes
    - [ ] No

20. Have you ever had a stress fracture?  
    - [ ] Yes
    - [ ] No

21. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)  
    - [ ] Yes
    - [ ] No

22. Do you regularly use a brace, orthotics, or other assistive device?  
    - [ ] Yes
    - [ ] No

23. Do you have a bone, muscle, or joint injury that bothers you?  
    - [ ] Yes
    - [ ] No

24. Do any of your joints become painful, swollen, feel warm, or look red?  
    - [ ] Yes
    - [ ] No

25. Do you have any history of juvenile arthritis or connective tissue disease?  
    - [ ] Yes
    - [ ] No

### MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?  
    - [ ] Yes
    - [ ] No

27. Have you ever used an inhaler or taken asthma medicine?  
    - [ ] Yes
    - [ ] No

28. Are there any in your family who have arthritis?  
    - [ ] Yes
    - [ ] No

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?  
    - [ ] Yes
    - [ ] No

30. Do you have a bunion or a painful blemish or bruise in the groin area?  
    - [ ] Yes
    - [ ] No

31. Have you had infectious mononucleosis (mono) within the last month?  
    - [ ] Yes
    - [ ] No

32. Do you have any rashes, pressure sores, or other skin problems?  
    - [ ] Yes
    - [ ] No

33. Have you had a herpes or MRSA skin infection?  
    - [ ] Yes
    - [ ] No

34. Have you ever had a head injury or concussion?  
    - [ ] Yes
    - [ ] No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?  
    - [ ] Yes
    - [ ] No

36. Do you have a history of seizures disorder?  
    - [ ] Yes
    - [ ] No

37. Do you have headaches with exercise?  
    - [ ] Yes
    - [ ] No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  
    - [ ] Yes
    - [ ] No

39. Have you ever been unable to move your arms or legs after being hit or falling?  
    - [ ] Yes
    - [ ] No

40. Have you ever become ill while exercising in the heat?  
    - [ ] Yes
    - [ ] No

41. Do you get frequent muscle cramps when exercising?  
    - [ ] Yes
    - [ ] No

42. Do you or someone in your family have sickle cell trait or disease?  
    - [ ] Yes
    - [ ] No

43. Have you had any heart problems? If so, please identify specific medical condition below.  
    - [ ] Yes
    - [ ] No

44. Have you had any eye injuries?  
    - [ ] Yes
    - [ ] No

45. Do you wear glasses or contact lenses?  
    - [ ] Yes
    - [ ] No

46. Do you wear protective eyewear, such as goggles or a face shield?  
    - [ ] Yes
    - [ ] No

47. Do you worry about your weight?  
    - [ ] Yes
    - [ ] No

48. Are you trying to or has anyone recommended that you gain or lose weight?  
    - [ ] Yes
    - [ ] No

49. Are you on a special diet or do you avoid certain types of foods?  
    - [ ] Yes
    - [ ] No

50. Have you ever had an eating disorder?  
    - [ ] Yes
    - [ ] No

51. Do you have any concerns that you would like to discuss with a doctor?  
    - [ ] Yes
    - [ ] No

52. Have you ever had a menstrual period?  
    - [ ] Yes
    - [ ] No

53. How old were you when you had your first menstrual period?  
    - [ ] Yes
    - [ ] No

54. How many periods have you had in the last 12 months?  
    - [ ] Yes
    - [ ] No

### FEAMLES ONLY

55. Do you have any history of heart problems or have you had a heart problem?  
    - [ ] Yes
    - [ ] No

56. Do you have any history of seizures disorder?  
    - [ ] Yes
    - [ ] No

57. Do you have any history of chest pain or heart murmur?  
    - [ ] Yes
    - [ ] No

58. Do you have any history of heart murmur or other heart problems?  
    - [ ] Yes
    - [ ] No

59. Do you have any history of heart problems or have you had a heart problem?  
    - [ ] Yes
    - [ ] No

### 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 ____________

# Preparticipation Physical Evaluation Form

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

## EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>/</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td>Vision R 20/</td>
<td>L 20/</td>
<td>Corrected</td>
</tr>
</tbody>
</table>

### MEDICAL

<table>
<thead>
<tr>
<th>Appearance</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes/ears/nose/throat</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pupils equal</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Lymph nodes</th>
<th></th>
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<table>
<thead>
<tr>
<th>Heart*</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Murmurs (auscultation standing, supine, +/- Valsalva)</td>
<td></td>
</tr>
<tr>
<td>Location of point of maximal impulse (PMI)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Pulses</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Simultaneous femoral and radial pulses</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Lungs</th>
<th></th>
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<table>
<thead>
<tr>
<th>Abdomen</th>
<th></th>
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<table>
<thead>
<tr>
<th>Genitourinary (males only)*</th>
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<table>
<thead>
<tr>
<th>Skin</th>
<th></th>
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<tbody>
<tr>
<td>HSV, lesions suggestive of MRSA, linea corporis</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurologic*</th>
<th></th>
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</table>

### MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Neck</th>
<th></th>
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<table>
<thead>
<tr>
<th>Back</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Shoulder/arm</th>
<th></th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Elbow/forearm</th>
<th></th>
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<table>
<thead>
<tr>
<th>Wrist/hand/fingers</th>
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<table>
<thead>
<tr>
<th>Hip/thigh</th>
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<table>
<thead>
<tr>
<th>Knee</th>
<th></th>
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<table>
<thead>
<tr>
<th>Leg/ankle</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Foot/toes</th>
<th></th>
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<table>
<thead>
<tr>
<th>Functional</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Duck-walk, single leg hop</td>
<td></td>
</tr>
</tbody>
</table>

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*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider (b) exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports

Reason

Recommendations

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) Date

Address Phone Signature of physician, MD or DO