PREPARTICIPATION PHYSICAL EXAMINATION

DATE OF EXAM_____/_____/_____

Name:_____ Sex:_____ Age:_____ DOB:_____/_____/_____

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

Address:_____ Phone: (_____)_____-_____

Name of Physician:_____

In case of emergency, contact:

Name:_____ Relationship:_____ Phone: (_____)_____-_____

Explain "Yes" answers below. Yes No

Circle questions you don't know the answers to

1. Has a doctor ever denied or restricted your participation in sports? ☐ ☐
2. Do you have an ongoing medical condition (like diabetes or asthma)? ☐ ☐
3. Are you currently taking any prescription or non-prescription (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): ☐ ☐
   - ☐ High blood pressure
   - ☐ A heart murmur
   - ☐ High cholesterol
   - ☐ A heart infection
10. Has a doctor ever ordered a test for your heart? (e.g. ECG, echocardiogram) ☐ ☐
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 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? ☐ ☐

For "Yes" answers to the following questions, circle the injury below

17. Have you ever had an injury that caused you to miss a game? ☐ ☐
18. Have you had any broken/fractured bones or dislocated joints? ☐ ☐
19. Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, or crutches? ☐ ☐

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 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? ☐ ☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ ☐
25. Is there anyone in your family who has asthma? ☐ ☐
26. Have you ever used an inhaler or taken asthma medicine? ☐ ☐
27. Were you born without or are you missing a kidney, eye, testicle, or other organ? ☐ ☐
28. Have you had infectious mononucleosis (mono) within the last month? ☐ ☐
29. Do you have 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 suffered from confusion or memory loss? ☐ ☐
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 in the heat, do you have 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? ☐ ☐

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?_____

IMMUNIZATIONS - INDICATE DATE

MMR _____ MENINGOCOCCAL _____

HEP A _____ TDAP _____

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:_____

Sports Preparticipation/General Physical Exam Form

Name:_____ DOB:_____/_____/_____

Height:_____ Weight: _____ BMI: _____ Pulse: _____ BP: _____

Vision R 20/_____ L 20/_____ Corrected? Y N UA_____ Hearing:

R				
L				

Follow-Up Questions on More Sensitive Issues

	Yes	No
1. Do you feel stressed out or under a lot of pressure?	☐	☐
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	☐	☐
3. Do you feel safe?	☐	☐
4. Have you ever tried cigarette smoking, even 1 or 2 puffs?	☐	☐
5. Do you currently smoke?	☐	☐
6. During the past 30 days, did you use chewing tobacco, snuff, or dip?	☐	☐
7. During the past 30 days, have you had at least 1 drink of alcohol?	☐	☐
8. Have you ever taken steroid pills or shots without a doctor's prescription?	☐	☐
9. Have you ever taken any supplements to help you gain or lose weight?	☐	☐
10. Have you ever taken any supplements to help improve your performance?	☐	☐
11. Do you have any concerns relating to behavior involving guns, seatbelt use, unprotected sex, domestic violence, drug use, etc. ?	☐	☐

Medications:_____ PMH:_____

Allergies:_____ PSH:_____

Activities:_____ Concussion Hx:_____

MEDICAL	Normal	Abnormal Findings	Deferred
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary			
Skin			
MUSCULOSKELETAL	**Normal**	**Abnormal Findings**	**Deferred**
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Activity Recommendations: ☐ No restrictions ☐ Restrictions:_____

Other Diagnoses:_____

_____

Name of Physician (print):_____Date:_____/_____/_____

Address:_____ Phone:_____

Signature of Physician:_____