PRE-PARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

Date of Exam:_____

Name	*Sex*	*Age*	*Date of Birth*
Grade	*School*		*Sport(s)*
Address		*Phone*	
Personal Physician			
In case of emergency, contact:			
Relationship	*Phone (H)*		*Phone (W)*

Explain 'yes' answers below. Circle questions you do not know the answers to.

1.Has a doctor ever denied or restricted your participation in sports for any reason?	Yes	No
2. Do you have an ongoing medical condition (like diabetes, asthma, etc.)?	Yes	No
3. Are you currently taking any prescription or non-prescription (over the counter) medication?	Yes	No
4. Do you have allergies to medicines, pollens, foods or stinging insects?	Yes	No
5. Have you ever passed out or nearly passed out DURING exercise?	Yes	No
6. Have you ever passed out or nearly passed out AFTER exercise?	Yes	No
7. Does your heart race or skip beats during exercise?	Yes	No
8. Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection	Yes	No
9. Has a doctor ever ordered a test for your heart (ECG, echocardiogram)?	Yes	No
10. Has anyone in your family died for no apparent reason?	Yes	No
11. Does anyone in your family have a heart problem?	Yes	No
12. Has any family member died from heart problems or of sudden death before the age of 50?	Yes	No
13. Does anyone in your family have Marfan syndrome?	Yes	No
14. Have you ever had surgery?	Yes	No
15. Have you ever spent the night in a hospital?	Yes	No

16. Have you ever had an injury like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? If yes, circle the affected area below:	Yes	No
17. Have you had any broken bones or dislocated joints? If yes, circle below:	Yes	No
18. 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:	Yes	No
Head Neck Shoulder Upper Arm Elbow Forearm Hand/Finger Chest Upper Back Lower Back Hip Thigh Knee Calf/shin Ankle Foot/toes	Yes	No
19. Have you ever had a stress fracture?	Yes	No
20. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Yes	No
21. Do you regularly use a brace or assistive device?	Yes	No
22. Has a doctor ever told you that you have asthma or allergies?	Yes	No
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
24. Is there anyone in your family who has asthma?	Yes	No
25. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	Yes	No
26. Do you have any rashes, pressure sores or other skin problems?	Yes	No
27. Have you had a herpes skin infection?	Yes	No
28. Have you ever had a head injury or concussion?	Yes	No
29. Have you been hit in the head and been confused or lost your memory?	Yes	No
30. Have you ever had a seizure?	Yes	No
31. Do you have headaches with exercise?	Yes	No
32. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	Yes	No
33. Have you ever been unable to move your arms or legs after being hit or falling?	Yes	No
34. When exercising in the heat, do you have severe muscle cramps or become ill?	Yes	No
35. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Yes	No
36. Have you had any problems with your eyes or vision?	Yes	No
37. Do you wear glasses or contact lenses?	Yes	No
38. Do you wear protective goggles or a face shield?	Yes	No
39. Are you happy with your weight?	Yes	No

40. Has anyone recommended you change your weight or eating habits?	Yes	No
41. Do you limit or carefully control what you eat?	Yes	No
42. Do you have any concerns that you would like to discuss with a doctor?	Yes	No
FEMALES ONLY		
43. Have you ever had a menstrual period?	Yes	No
44. How old were you when you had your first menstrual period?		
45. How many periods have you had in the last 12 months?		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete Date

Signature of parent/guardian Date

PHYSICAL EXAMINATION FORM

*Name:*_____
*Date of Birth:*_____
*Height:*_____ *Weight:*_____
*Pulse:*_____ *Blood Pressure:*_____

Vision: R 20 / _____ *L 20 /* _____
Corrected: Y ☐ *N* ☐
Pupils: Equal _____ *Unequal* _____

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

NOTES: _____

_____

_____

_____
Printed Name of Physician/Signature of Physician Date

_____
Address/Phone

CLEARANCE FORM

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: _____

Recommendations: _____

_____

_____

EMERGENCY INFORMATION

Allergies: _____

Other information: _____

IMMUNIZATIONS (e.g., 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)

_____

Address/Phone

_____

Signature of Physician/Date