# PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name: _____ Birth Date: _____

Address: _____ City: _____ Zip: _____

## HISTORY

| | Yes | No | |
|---|---|---|---|
| 1 a. | ___ | ___ | Have you had any illness/injury recently, or do you have an illness/injury now? |
| b. | ___ | ___ | Do you have any chronic or recurrent illness? |
| c. | ___ | ___ | Have you ever had any injuries requiring treatment by a physician? |
| 2. | ___ | ___ | Are you presently taking ANY medications (including vitamin, aspiring, etc.)? |
| 3. | ___ | ___ | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4 a. | ___ | ___ | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| b. | ___ | ___ | Have you ever had any problem with your blood pressure or your heart? |
| c. | ___ | ___ | Have any close relatives had heart problems, heart attack or sudden death before age 50? |
| 5 a. | ___ | ___ | Have you ever had fainting, convulsions, seizures or severe dizziness? |
| b. | ___ | ___ | Do you have frequent headaches? |
| c. | ___ | ___ | Have you ever been “knocked out” or “passed out”? |
| d. | ___ | ___ | Have you ever had a neck or head injury? |
| 6. | ___ | ___ | Have you ever had heat exhaustion, heat stroke, or heat cramps? |
| 7. | ___ | ___ | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 8 a. | ___ | ___ | Do you wear eyeglasses, contact lenses or protective eye wear? |
| b. | ___ | ___ | Have you had any problem with your eyes or vision? |
| 9 a. | ___ | ___ | Have you ever had a knee injury? |
| b. | ___ | ___ | Have you ever had an ankle injury? |
| c. | ___ | ___ | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| d. | ___ | ___ | Have you ever had a broken bone (fracture)? |
| 10. | ___ | ___ | Have you any medical concerns about participating in track? |

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

EXAMINER’S COMMENTS ON ALL “YES” ANSWERS (refer to question number):

_____

_____

_____

# PHYSICAL EXAMINATION

Age: _____ Pulse: _____ Height: _____ Blood Pressure: _____

| | Normal | Abnormal | |
|---|---|---|---|
| 1. Head | ____ | ____ | _____ |
| 2. Eyes (pupils) | ____ | ____ | _____ |
| 3. Teeth | ____ | ____ | _____ |
| 4. Chest | ____ | ____ | _____ |
| 5. Lungs | ____ | ____ | _____ |
| 6. Heart | ____ | ____ | _____ |
| 7. Abdomen | ____ | ____ | _____ |
| 8. Neurologic | ____ | ____ | _____ |
| 9. Skin | ____ | ____ | _____ |
| 10. Spine, Back | ____ | ____ | _____ |
| 11. Shoulders | ____ | ____ | _____ |
| 12. Arms | ____ | ____ | _____ |
| 13. Legs | ____ | ____ | _____ |

Assessment:

____ Full participation

____ Limited participation (describe limitations, restrictions):

_____

_____

_____

____ Participation contraindicated (list reasons):

_____

_____

_____

Recommendations (equipment, taping, rehabilitation, etc.):

_____

_____

_____

_____

Examiner's Signature: _____

Print Examiner's Name: _____

Date: _____