

Revised 7/1/05
Mandatory

Preparticipation Physical Evaluation

Date of Exam _____

HISTORY FORM

Name _____ Sex _____ Age _____ Date of
birth _____
Grade _____ School _____ Sport(s) _____
Address _____ 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.

1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have an ongoing medical condition (like diabetes or asthma)?
3. Are you currently taking any prescription or nonprescription (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? (for example: 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 of 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?
Yes No
Yes No

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, an eye, a testicle, or any 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 been confused or lost your memory?
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 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?
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:
19. 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:
 Head Neck Shoulder Upper Elbow Forearm Hand/ Chest
 Arm Fingers
 Upper Lower Hip Thigh Knee Calf/ Ankle Foot/
 Back BackShin Toes
48. How old were you when you had your first menstrual period? _____
49. How many periods have you had in the last 12 months? _____
 Explain "Yes" answers here: _____

20. Have you ever had a stress fracture?
21. Have you been told that you have or have you had an x-ray for atlantoaxial (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?

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 _____

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Name _____ Date of Birth _____
Height _____ weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____ (_____/_____, ____/____)
Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal _____ Unequal _____

NORMAL ABNORMAL FINDINGS INITIALS*

- MEDICAL
- 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

*Multiple-examiner set-up only.
+Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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Preparticipation Physical Evaluation 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: _____ Reason: _____
Recommendations: _____

EMERGENCY INFORMATION
Allergies

Other Information

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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Preparticipation Physical Evaluation CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

C
C
Cleared without restriction
Cleared, with recommendations for further evaluation or treatment
for: _____

Not Cleared for

All sports

Certain sports: _____ Reason: _____
Recommendations: _____

EMERGENCY INFORMATION
Allergies

Other Information

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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