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

Name

Sex   Age   Grade   School   Sport(s)

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

Do you have any allergies?   Yes   No   If yes, please identify specific allergy below.

☐ Medicines   ☐ Pollens   ☐ Food   ☐ Stinging Insects

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:
   Yes   No

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:
   Yes   No

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 unexpected or 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 hypertrophic cardiomyopathy, Marfan syndrome, arrhythmic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?
    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 have you 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. Is there anyone in your family who has asthma?
    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 groin pain or a painful bulge or hernia 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 seizure 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 problems with your eyes or vision?
    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

FEMALES ONLY

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

Explain “yes” answers here

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

## PHYSICAL EXAMINATION FORM

**Name**

**Date of birth**

### 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>Pulse</td>
<td>☐ Corrected</td>
<td>☐ Y ☐ N</td>
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</tbody>
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### MEDICAL

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
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<tbody>
<tr>
<td>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
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<table>
<thead>
<tr>
<th>Eyes/ears/nose/throat</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pupils equal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hearing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lymph nodes</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Heart*</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Murmurs (auscultation standing, supine, +/- Valsalva)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Location of point of maximal impulse (PMI)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Pulses</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Simultaneous femoral and radial pulses</td>
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<table>
<thead>
<tr>
<th>Lungs</th>
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<th>Abnormal Findings</th>
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</thead>
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<table>
<thead>
<tr>
<th>Abdomen</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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</thead>
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<table>
<thead>
<tr>
<th>Genitourinary (males only)*</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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</table>

<table>
<thead>
<tr>
<th>Skin</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HSV, lesions suggestive of MRSA, linea corporis</td>
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<td></td>
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<table>
<thead>
<tr>
<th>Neurologic*</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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### MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Neck</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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</table>

<table>
<thead>
<tr>
<th>Back</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Shoulder/arm</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elbow/forearm</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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<table>
<thead>
<tr>
<th>Wrist/hand/fingers</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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</thead>
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<table>
<thead>
<tr>
<th>Hip/thigh</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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</thead>
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<table>
<thead>
<tr>
<th>Knee</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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</thead>
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<table>
<thead>
<tr>
<th>Leg/ankle</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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<table>
<thead>
<tr>
<th>Foot/toes</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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<table>
<thead>
<tr>
<th>Functional</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Duck-walk, single leg hop</td>
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*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider (G) 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 Signature of parent MD or DO

Preparticipation Physical Evaluation
CLEARANCE FORM

Name __________________________________________ Sex ☐ M ☐ F Age ______________ Date of birth ______________

☐ 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

EMERGENCY INFORMATION

Allergies ____________________________________________________________

Other information ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________