Preparticipation Physical Evaluation Form

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Date of exam: _____ dd / mm / yyyy

HISTORY FORM

Note: Patients and parents must complete this form before the medical evaluation. It stays in the individual's medical file and is not sent to the athletic department.

Client information: _____ **Sex:** _____

Sport(s): _____

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

Do you carry an inhaler?

◯ Yes ◯ No

Do you carry an epi-pen?

◯ Yes ◯ No

Do you have any allergies?

◯ Yes ◯ No

If yes, identify specific allergy below

- ☐ Medicines
- ☐ Pollens
- ☐ Food
- ☐ Stinging Insects
- ☐ Latex
- ☐ Other

GENERAL QUESTIONS

Has a doctor ever denied or restricted your participation in sports for any reason?

◯ Yes ◯ No

Have you ever been admitted to the hospital?

◯ Yes ◯ No

Do you have any ongoing medical conditions?

◯ Yes ◯ No

If so, please identify below

- ☐ Asthma
- ☐ Anemia
- ☐ Diabetes
- ☐ Infections
- ☐ Sickle cell disease or trait
- ☐ Other

Have you ever had surgery?

◯ Yes ◯ No

HEART HEALTH QUESTIONS

Have you ever passed out or nearly passed out during or after exercise?

◯ Yes ◯ No

Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?

◯ Yes ◯ No

Has a doctor ever told you that you have any heart problems?

◯ Yes ◯ No

If so, check all that apply

- ☐ High blood pressure
- ☐ A heart murmur
- ☐ High cholesterol
- ☐ A heart infection
- ☐ Kawasaki disease
- ☐ Other

Has a doctor ever ordered a test for your heart? (e.g., ECG/EKG, echocardiogram)

◯ Yes ◯ No

Do you get lightheaded or feel more short of breath than expected during exercise?

◯ Yes ◯ No

Do you get more tired or short of breath more quickly than your friends during exercise?

◯ Yes ◯ No

Have you ever had any heart surgery?

◯ Yes ◯ No

Does anyone in your family have an irregular heartbeat?

◯ Yes ◯ No

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 accidents, or sudden infant death syndrome)?

◯ Yes ◯ No

Does anyone in your family have a heart problem, pacemaker, or defibrillator?

◯ Yes ◯ No

Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

◯ Yes ◯ No

BONE AND JOINT QUESTIONS

Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?

◯ Yes ◯ No

Have you ever had any broken or fractured bones or dislocated joints?

◯ Yes ◯ No

Have you ever had an injury that required X-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?

◯ Yes ◯ No

Have you ever had a stress fracture?

◯ Yes ◯ No

Have you ever been told that you have or had an x-ray for neck instability? (e.g., Down syndrome or dwarfism)

◯ Yes ◯ No

Do you regularly use a brace, orthotics, or other device?

◯ Yes ◯ No

Do you have a bone, muscle, or joint injury that bothers you?

◯ Yes ◯ No

MEDICAL QUESTIONS

Do you have any history of juvenile arthritis or connective tissue disease?

◯ Yes ◯ No

Do any of your joints become painful, swollen, warm, or look red?

◯ Yes ◯ No

Do you cough, wheeze, or have difficulty breathing during or after exercise?

◯ Yes ◯ No

Have you ever used an inhaler or taken asthma medicine?

◯ Yes ◯ No

Is there anyone in your family who has asthma?

◯ Yes ◯ No

Were you born without, or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?

◯ Yes ◯ No

Do you have groin pain or a painful bulge or hernia in the groin area?

◯ Yes ◯ No

Have you had infectious mononucleosis (mono) within the last month?

◯ Yes ◯ No

Do you have any rashes, pressure sores, or other skin problems?

◯ Yes ◯ No

Have you had a herpes or MRSA skin infection?

◯ Yes ◯ No

Have you ever had a head injury or concussion?

◯ Yes ◯ No

Have you ever had an unexplained seizure?

◯ Yes ◯ No

Have you ever had a hit or blow to the head that caused confusion, long-lasting headaches, or memory problems?

◯ Yes ◯ No

Do you have a history of seizure disorder?

◯ Yes ◯ No

Do you have headaches with exercise?

◯ Yes ◯ No

Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?

◯ Yes ◯ No

Have you ever been unable to move your arms or legs after being hit or falling?

◯ Yes ◯ No

Have you ever become ill while exercising in the heat?

◯ Yes ◯ No

Do you get frequent muscle cramps when exercising?

◯ Yes ◯ No

Have you had any problems with your eyes or vision?

◯ Yes ◯ No

Have you had any eye injuries?

◯ Yes ◯ No

Do you wear glasses or contact lenses?

◯ Yes ◯ No

Do you wear protective eyewear, such as goggles or a face shield?

◯ Yes ◯ No

Have you ever had hearing loss or problems with your hearing?

◯ Yes ◯ No

Do you worry about your weight?

◯ Yes ◯ No

Are you trying to or has anyone recommended that you gain or lose weight?

◯ Yes ◯ No

Are you on a special diet or do you avoid certain types of foods?

◯ Yes ◯ No

Have you ever had an eating disorder?

◯ Yes ◯ No

Do you have any concerns that you would like to discuss with a doctor?

◯ Yes ◯ No

Do you have any other medical problems?

◯ Yes ◯ No

FEMALES ONLY

Have you ever had a menstrual period?

◯ Yes ◯ No

Have you had any problems with your periods (e.g., severe cramps, heavy bleeding)?

◯ Yes ◯ No

When was your last period?: _____ **What is the frequency of your periods?:** _____

CONSENT

Parent /Guardian name and signature
Date: _____ dd / mm / yyyy

Note: This form should be retained in the individual's medical file and is not to be returned to the athletic department.

PHYSICAL EXAMINATION FORM

Do you feel safe at your home or residence?

◯ Yes ◯ No

Notes

Do you feel safe at school?

◯ Yes ◯ No

Notes

Do you ever feel stressed or under pressure?

◯ Yes ◯ No

Notes

Do you feel sad, hopeless, depressed, or anxious?

◯ Yes ◯ No

Notes

Have there been changes in your weight?

◯ Yes ◯ No

Notes

Have you taken supplements to gain/lose weight or improve performance?

◯ Yes ◯ No

Notes

Have you tried cigarettes, alcohol, or drugs?

◯ Yes ◯ No

Notes

Have you taken anabolic steroids or other performance supplements?

◯ Yes ◯ No

Notes

Do you wear a seat belt?

◯ Yes ◯ No

Notes

Are you using contraceptives?

◯ Yes ◯ No

Notes

Are you sexually active?

◯ Yes ◯ No

Notes

In the past 30 days, did you use cigarettes, alcohol, or drugs?

◯ Yes ◯ No

Notes

EXAMINATION

Height: _____ **Weight:** _____

Sex

◯ Male ◯ Female

BP: _____ **Pulse:** _____

Vision: _____

Corrected

◯ Yes ◯ No

MEDICAL

Is the appearance normal?

◯ Yes ◯ No

Abnormal findings

Is the eyes/ears/nose/throat normal?

◯ Yes ◯ No

Abnormal findings

Is the lymph node normal?

◯ Yes ◯ No

Abnormal findings

Is the heart (murmurs, PMI, etc.) normal?

◯ Yes ◯ No

Abnormal findings

Is the pulse normal?

◯ Yes ◯ No

Abnormal findings

Is the lungs normal?

◯ Yes ◯ No

Abnormal findings

Is the abdomen normal?

◯ Yes ◯ No

Abnormal findings

Is the genitourinary (males only) normal?

◯ Yes ◯ No

Abnormal findings

Is the skin (HSV, MRSA, Tinea corporis) normal?

◯ Yes ◯ No

Abnormal findings

Is the neurological normal?

◯ Yes ◯ No

Abnormal findings

MUSCULOSKELETAL

Is the neck normal?

◯ Yes ◯ No

Abnormal findings

Is the back (including scoliosis) normal?

◯ Yes ◯ No

Abnormal findings

Is the shoulder/arm normal?

◯ Yes ◯ No

Abnormal findings

Is the elbow/forearm normal?

◯ Yes ◯ No

Abnormal findings

Is the wrist/hand/fingers normal?

◯ Yes ◯ No

Abnormal findings

Is the hip/thigh normal?

◯ Yes ◯ No

Abnormal findings

Is the knee normal?

◯ Yes ◯ No

Abnormal findings

Is the leg/ankle normal?

◯ Yes ◯ No

Abnormal findings

Is the foot/toes normal?

◯ Yes ◯ No

Abnormal findings

Is it functional (duck-walk, hop)?

◯ Yes ◯ No

Abnormal findings

PROVIDER INFORMATION

Name of medical provider: _____ **License/NPI number:** _____

Address: _____ **Phone:** _____

_____

Signature