PRE-PARTICIPATION 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 A COPY OF THIS FORM IN THE CHART FOR THEIR RECORDS).

Name				**Date of Exam**			
Date of Birth				**Age**		**Sex**	
Grade		**Sport**	☐ **Volleyball** ☐ **Football** ☐ **Cross Country** ☐ **Basketball** ☐ **Baseball** ☐ **Soccer**				

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 or on another sheet of paper. Circle questions you do not know the answer to.

GENERAL QUESTIONS	**Yes**	**No**		**MEDICAL QUESTIONS**	**Yes**	**No**
1. Has a doctor ever denied or restricted your participation in sports for any reason?				21. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections				22. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?				23. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?				24. Were you born without or are you missing a kidney, an eye, a testicle (males) or spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**		25. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?				26. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				27. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?				28. Have you ever had a head injury or concussion?		
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:				29. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)				30. Do you have a history of seizure disorder?		
10. Have you ever had an unexplained seizure?				31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**		32. Have you ever been unable to move your arms or legs after being hit or falling?		
11. 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)?				33. Have you ever become ill while exercising in the heat?		
12. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?				34. Do you get frequent muscle cramps when exercising?		
13. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				35. Have you had any problems with your eyes or vision?		
14. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?				36. Do you wear glasses or contact lenses?		
BONE AND JOINT QUESTIONS	**Yes**	**No**		37. Are you trying to or has anyone recommended that you gain or lose weight?		
15. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?				38. Are you on a special diet or do you avoid certain types of foods?		
16. Have you ever had any broken or fractured bones or dislocated joints?				39. Have you ever had an eating disorder?		
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				**FEMALES ONLY**		
18. 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)				40. Have you ever had a menstrual period?		
19. Do you regularly use a brace, orthotics, or other assistive device?				41. How old were you when you had your first menstrual period?		
20. Do you have a bone, muscle, or joint injury that bothers you?				42. 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:	**Signature of Parent(s) or Guardian:**	**Date:**

PRE-PARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name:	**Date of Birth:**		
EXAMINATION			
Height:	Weight:	☐ Male	☐ Female
BP: / (/)	Pulse:	Vision: R 20/ L 20/	Corrected: ☐ Yes ☐ No

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart***** • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal pulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)******		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic*******		

MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*** Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam;**
****Consider GU 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 (please list):

Reason:

Recommendations:

I have examined the above-named student and completed the pre-participation 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 (type/print):	**Date:**
Address:	**Phone:**
Signature of Physician (MD/DO/ARNP/PA/Chiropractor):	