



PREPARTICIPATION PHYSICAL EVALUATION

Name _____ Age _____ Gender _____ Date of Birth _____
 Address _____ Phone _____
 School _____ Grade _____ Sports _____
 Height _____ Weight _____ Personal Physician _____ Physician's Phone _____

Medical History Questionnaire - This section must be completed before your examination. Include dates of any problems and explain all yes answers. Please sign in appropriate spaces below.

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Are you currently under a doctor's care for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Do you wear glasses or contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Do you use any special equipment (splints, neck rolls, mouth guards, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Has anyone in your family died of heart problem or sudden death before the age of 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking an medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Do you have only one working organ of usually paired organs (only one eye, kidney, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergies (medicines, bee stings, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have you ever sprained, broken, dislocated or had repeated swelling or pain of any bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been dizzy or fainted during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had chest pains during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you had any medical problems or injuries? (asthma, mono, diabetes, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have you had any medical problems or injuries since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Were there any special instructions or precautions given by the Medical Practitioner? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had a racing heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | 27. What was the date of your last tetanus shot? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | 28. (Women Only) Date of first menstrual period: _____
When was your last menstrual period? _____
What was the longest period of time between your periods last year? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 13. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 14. Are any of the following currently bothering you?
Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/>
Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Foot <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 15. Have you ever been dizzy or passed out due to the heat? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 16. Do you have trouble breathing before or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 17. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Explain all "Yes" answers by question number and indicate dates for each item (include any special instructions):

I/We hereby state that, to the best of my/our knowledge, the answers to the above questions are correct. I/We understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this individual.

Signature of Athlete _____ Date _____

Signature of Parent or Guardian (if athlete is under 18) _____ Date _____

	Blood Pressure	HEENT	Skin	Heart	Lungs	Abdomen	Flexibility/Strength
NORMAL							
ABNORMAL							

While this does not constitute a complete physical examination nor replace the need for periodic health evaluations by a family physician, this individual appears to be physically capable of participation in interscholastic sports as of this date, except as indicated below.

- Cleared for sports without restrictions
- Cleared with the following restrictions: _____
- Cleared after completing evaluation/rehabilitation for: _____
- Not Cleared

At this athlete's screening exam the following is/are noted:

Condition/Sign/Symptoms with Simple Explanation/Recommendations

- Elevated (High) Blood Pressure. Increase in pressures in the artery during the beating and resting heart . Maximum normal (age group) ___/___
- Heart Murmur. Flow of blood through the heart which is audible. In this case, it is: "Functional" (normal) Abnormal.
- Asthma . Blockage of small airways in the lung . Use inhaler as prescribed and 30 minutes before exercise.
- Allergic Reactions to Stings or Bites. includes whole body swelling & shortness of breath Epinephrine injector should be available at all times.
- Diabetes. Abnormal sugars and sugar metabolism. Continue close monitoring with M.D.
- Scoliosis. Curvature of the spine. Continue close monitoring with M.D.
- Orthopaedic Problem. Being seen by M.D. for this condition Should be cleared for play by M.D.
- Concussion. Further evaluation required before athletic participation permitted.
- Other _____

Physician's Name _____ Physician's Signature _____ Date _____