

PRE-PARTICIPATION HISTORY & PHYSICAL EXAM

Name: _____ Sex: F M Age: _____ Date of Birth: _____
 Grade: _____ School: _____ Sport(s) Please list ALL: _____
 Address: _____ Phone: _____
 Personal Physician: _____ None
 Emergency Contact Name: _____ Relationship: _____ Phone#(s): _____

Attention parent or guardian and athlete: answers to the following questions are very important!!! Please take the time, read through the questions, and answer to the best of your knowledge.

General Medical History:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have sickle cell trait? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any other major medical problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been hospitalized or had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you cough, wheeze or have trouble breathing with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a single organ (testicle or kidney)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever taken any supplements or vitamins to help with weight loss, weight gain, or improve performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any allergies (seasonal, insects, food, or medicines)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have any skin problems other than acne? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a head injury, been knocked out, lost your memory, had your "bell rung," or a concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had mononucleosis or any significant illness in the last 60 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have trouble with your eyes/vision/ wear glasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have trouble with your hearing/wear hearing aid(s)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you lose weight regularly to meet weight requirements for your sport or other reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you feel stressed out, tired, or depressed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are there any other issues you would like to discuss with the doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are your immunizations up to date? | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES ONLY

- | | | |
|---|--------------------------|--------------------------|
| 27. Are your periods regular (every month)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Are your periods heavy? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers here (use back/page 2 if needed): _____

Cardiac History:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had chest pain or chest pressure during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you tire easily or more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been told you had a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been told you had an enlarged or weak heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has any member of your family: | | |
| -died of heart problems or sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| -been told they had a serious heart problem before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| -been told they had Marfan's syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a physician ever denied or restricted your participation in sports? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers here: _____

Orthopaedic History:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever broken or fractured any bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever subluxed or dislocated any joint? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had any other problems related to your: | | |
| -neck, spine, or back? | <input type="checkbox"/> | <input type="checkbox"/> |
| -shoulders? | <input type="checkbox"/> | <input type="checkbox"/> |
| -elbows? | <input type="checkbox"/> | <input type="checkbox"/> |
| -wrists, hands, or fingers? | <input type="checkbox"/> | <input type="checkbox"/> |
| -hips? | <input type="checkbox"/> | <input type="checkbox"/> |
| -knees? | <input type="checkbox"/> | <input type="checkbox"/> |
| -ankles, feet, or toes? | <input type="checkbox"/> | <input type="checkbox"/> |
| -other? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers here (put date of injury if known): _____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

PRE-PARTICIPATION SPORTS PHYSICAL EXAM

Height _____ Weight _____ Pulse _____ B/P (R arm) _____

Medical	Normal	Abnormal Findings
Appearance/Emotional Affect		
Head/Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart (squatting to standing and supine)		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
Musculoskeletal	Normal	Abnormal Findings
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

May Participate in all sports, *EXCEPT* those listed below:

May Participate after completing evaluation/rehabilitation for: _____

May Not Participate – Reason: _____

Recommendations: _____

Signature of Medical Practitioner: _____ Date of Exam: _____

Printed Name: _____

Phone Number: _____

Extra Space for "YES" answers from the front: _____
