

Pre-participation Physical Evaluation

History _____ Date _____
 Name _____ Sex _____ Age _____ Date of Birth _____
 Grade _____ Sport _____
 Personal physician _____ Address _____ Physician Phone _____

Yes No

Explain "Yes" answers below:

1. Have you ever been hospitalized? Yes No
 Have you ever had surgery? Yes No
2. Are you presently taking any medications or pills? Yes No
3. Do you have any allergies (medicine, bees or other stinging insects)? Yes No
4. Have you ever passed out during or after exercise? Yes No
 Have you ever been dizzy during or after exercise? Yes No
 Have you ever had chest pain during or after exercise? Yes No
 Do you tire more quickly than you friends during exercise? Yes No
 Have you ever had high blood pressure? Yes No
 Have you ever been told that you have a heart murmur? Yes No
 Have you ever had racing of your heart or skipped heartbeats? Yes No
 Has anyone in your family died of heart problems or a sudden death before age 50? Yes No
5. Do you have any skin problems (itching, rashes, acne)? Yes No
6. Have you ever had a head injury? Yes No
 Have you ever been knocked out or unconscious? Yes No
 Have you ever had a seizure? Yes No
 Have you ever had a stinger, burner, or pinched nerve? Yes No
7. Have you ever had heat or muscle cramps? Yes No
 Have you ever been dizzy or passed out in the heat? Yes No
8. Do you have trouble breathing or do you cough during or after activity? Yes No
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? Yes No
10. Have you had any problems with your eyes or vision? Yes No
 Do you wear glasses or contacts or protective eye wear? Yes No
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling, or other injuries of any bones? Yes No
 Head Shoulder Thigh Neck Elbow Knee Chest Forearm
 Shin/calf Back Wrist Ankle Hip Hand Foot
12. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? Yes No
13. Have you had a medical problem or injury since your last evaluation?..... Yes No
14. When was you last tetanus shot? _____
 When was you last measles immunization? _____
15. When was your first menstrual period? _____
 When was your last menstrual period? _____
 What was the longest time between your periods last year? _____

Explain "Yes" Answers: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.
 Date _____ Signature of athlete _____
 Signature of parent/guardian _____

Pre-participation Physical Evaluation (Continued)

Physical Examination

Date _____

Name _____ Age _____ Date of Birth _____

Height _____		Weight _____		BP _____ / _____		Pulse _____		
Vision R 20/ _____		L20/ _____		Corrected: Y N		Pupils _____		
COMPLETE	LIMITED		Normal		Abnormal Findings			Initials
		Cardiopulmonary						
		Pulses						
		Heart						
		Lungs						
		Tanner stage	1	2	3	4	5	
	Skin							
	Abdominal							
	Genitalia							
	Musculoskeletal							
	Neck							
	Shoulder							
	Elbow							
	Wrist							
	Hand							
Back								
Knee								
Ankle								
Foot								
Other								

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: _____
- C. Not cleared for: Collision
 Contact
 Non-contact _____ Strenuous _____ Moderately strenuous _____ Non-strenuous

Due to: _____

Recommendation: _____

Name of physician _____ Date _____

Address _____ Phone _____

Signature of physician _____