## Preparticipation Physical Evaluation

**HISTORY FORM**

**Date of Exam** __________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Date of birth</th>
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<table>
<thead>
<tr>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
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**Personal Physician** __________________________________________________________________________________

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<tr>
<th>Phone</th>
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**In case of emergency, contact:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone (H)</th>
<th>Phone (W)</th>
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**Explain "Yes" answers below. Circle questions you don't know the answers to.**

1. Has a doctor ever denied or restricted your participation in sports for any reason?  
   - Yes ☐  No ☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?  
   - Yes ☐  No ☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?  
   - Yes ☐  No ☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?  
   - Yes ☐  No ☐
5. Have you ever passed out or nearly passed out during exercise?  
   - Yes ☐  No ☐
6. Have you ever passed out or nearly passed out after exercise?  
   - Yes ☐  No ☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?  
   - Yes ☐  No ☐
8. Does your heart race or skip beats during exercise?  
   - Yes ☐  No ☐
9. Have a doctor ever told you that you have (check all that apply):  
   - High blood pressure ☐  A heart murmur ☐  A heart infection ☐
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)  
    - Yes ☐  No ☐
11. Has anyone in your family died for no apparent reason?  
    - Yes ☐  No ☐
12. Does anyone in your family have a heart problem?  
    - Yes ☐  No ☐
13. Has anyone in your family (like diabetes or asthma)?  
    - Yes ☐  No ☐
14. Does anyone in your family have Marfan syndrome?  
    - Yes ☐  No ☐
15. Have you ever slept the night in a hospital?  
    - Yes ☐  No ☐
16. Have you ever had surgery?  
    - Yes ☐  No ☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game?  
    - Yes ☐  No ☐
18. Have you had any broken or fractured bones or dislocated joints?  
    - Yes ☐  No ☐
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?  
    - Yes ☐  No ☐
20. Have you ever had a stress fracture?  
    - Yes ☐  No ☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?  
    - Yes ☐  No ☐
22. Do you regularly use a brace or assistive device?  
    - Yes ☐  No ☐
23. Has a doctor ever told you that you have asthma or allergies?  
    - Yes ☐  No ☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?  
    - Yes ☐  No ☐
25. Is there anyone in your family who has asthma?  
    - Yes ☐  No ☐
26. Have you ever used an inhaler or taken asthma medicine?  
    - Yes ☐  No ☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?  
    - Yes ☐  No ☐
28. Have you had infectious mononucleosis (mono) within the last month?  
    - Yes ☐  No ☐
29. Do you have any rashes, pressure sores, or other skin problems?  
    - Yes ☐  No ☐
30. Have you had a herpes skin infection?  
    - Yes ☐  No ☐
31. Have you ever had a head injury or concussion?  
    - Yes ☐  No ☐
32. Have you been hit in the head and been confused or lost your memory?  
    - Yes ☐  No ☐
33. Have you ever had a seizure?  
    - Yes ☐  No ☐
34. Do you have headaches with exercise?  
    - Yes ☐  No ☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  
    - Yes ☐  No ☐
36. Have you ever been unable to move your arms or legs after being hit or falling?  
    - Yes ☐  No ☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?  
    - Yes ☐  No ☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?  
    - Yes ☐  No ☐
39. Have you had any problems with your eyes or vision?  
    - Yes ☐  No ☐
40. Do you wear glasses or contact lenses?  
    - Yes ☐  No ☐
41. Do you wear protective eyewear, such as goggles or a face shield?  
    - Yes ☐  No ☐
42. Are you happy with your weight?  
    - Yes ☐  No ☐
43. Are you trying to gain or lose weight?  
    - Yes ☐  No ☐
44. Has anyone recommended you change your weight or eating habits?  
    - Yes ☐  No ☐
45. Do you limit or carefully control what you eat?  
    - Yes ☐  No ☐
46. Do you have any concerns that you would like to discuss with a doctor?  
    - Yes ☐  No ☐
47. Have you ever had a menstrual period?  
    - Yes ☐  No ☐
48. How old were you when you had your first menstrual period?  
    - Yes ☐  No ☐
49. How many periods have you had in the last 12 months?  
    - Yes ☐  No ☐

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**FEMALES ONLY**

46. Do you have any concerns that you would like to discuss with a doctor?  
    - Yes ☐  No ☐
47. Have you ever had a menstrual period?  
    - Yes ☐  No ☐
48. How old were you when you had your first menstrual period?  
    - Yes ☐  No ☐
49. How many periods have you had in the last 12 months?  
    - Yes ☐  No ☐

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**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

<table>
<thead>
<tr>
<th>Signature of Athlete</th>
<th>Signature of Parent/Guardian</th>
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Preparticipation Physical Evaluation

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
<th>INITIALS*</th>
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<tbody>
<tr>
<td>Appearance</td>
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</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
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<tr>
<td>Hearing</td>
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<tr>
<td>Lymph nodes</td>
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<td></td>
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<tr>
<td>Heart</td>
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<tr>
<td>Murmurs</td>
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<tr>
<td>Pulses</td>
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<tr>
<td>Lungs</td>
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</tr>
<tr>
<td>Abdomen</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary (males only)+</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
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| MUSCULOSKELETAL                              |        |                   |           |
| Neck                                         |        |                   |           |
| Back                                         |        |                   |           |
| Shoulder/arm                                 |        |                   |           |
| Elbow/forearm                                |        |                   |           |
| Wrist/hand/fingers                           |        |                   |           |
| Hip/thigh                                    |        |                   |           |
| Knee                                         |        |                   |           |
| Leg/ankle                                    |        |                   |           |
| Foot/ toes                                   |        |                   |           |

*Multiple-examiner set-up only.
+Having a third party present is recommended for the genitourinary examination.

Notes:  
____________________________________________________________________________________________________________________________________________________________________________________________________________

Name of physician (print/type) ___________________________________________ Date ____________________

Address ___________________________________________________________________________ Phone ____________________

Signature of physician ____________________________________________________________, MD or DO

Preparticipation Physical Evaluation

Cleared without restriction
Cleared, with recommendations for further evaluation or treatment for:

Not Cleared for

All sports
Certain sports:

Reason:

Recommendations:

EMERGENCY INFORMATION

Allergies

Other Information

Name of physician (print/type) Date
Address Phone
Signature of physician, MD or DO