PREPARTICIPATION PHYSICAL FORM

DATE OF EXAM: ____/___/_____

HISTORY

Name: _____ Sex: ❑ Male, ❑ Female Age: _____ Date of birth: ____/___/_____

Grade: _____ School:_____ Sport(s): _____

Address: _____Phone:_____

Personal physician: _____

In case of emergency, contact

Name: _____ Relationship: _____Phone (H): _____ (W) : _____

Explain "Yes" answers below.
Circle questions you don't know the answers to

	YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?	❑	❑
Do you have an ongoing or chronic illness?	❑	❑
2. Have you ever been hospitalized overnight?	❑	❑
Have you ever had surgery?	❑	❑
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	❑	❑
Have you ever taken any supplements/vitamins to help you gain or lose weight or improve your performance?	❑	❑
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	❑	❑
Have you ever had a rash or hives develop during or after exercise?	❑	❑
5. Have you ever passed out during or after exercise?	❑	❑
Have you ever been dizzy during or after exercise?	❑	❑
Have you ever had chest pain during or after exercise?	❑	❑
Do you get tired more quickly than your friends do during exercise?	❑	❑
Have you ever had racing of your heart or skipped heartbeats?	❑	❑
Have you had high blood pressure or high cholesterol?	❑	❑
Have you ever been told you have a heart murmur?	❑	❑
Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	❑	❑
Has a physician ever denied or restricted your participation in sports for any heart problems?	❑	❑
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	❑	❑
7. Have you ever had a head injury or concussion?	❑	❑
Have you ever been knocked out, become unconscious, or lost your memory?	❑	❑
Have you ever had a seizure?	❑	❑
Do you have frequent or severe headaches?	❑	❑
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	❑	❑
Have you ever had a stinger, burner, or pinched nerve?	❑	❑
8. Have you ever become ill from exercising in the heat?	❑	❑
9. Do you cough, wheeze, or have trouble breathing during or after activity?	❑	❑
Do you have asthma?	❑	❑
Do you have seasonal allergies that require medical treatment?	❑	❑
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	❑	❑
11. Have you had any problems with your eyes or vision?	❑	❑
Do you wear glasses, contacts, or protective eyewear?	❑	❑
12. Have you ever had a sprain, strain, or swelling after injury?	❑	❑
Have you broken or fractured any bones or dislocated any joints?	❑	❑
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	❑	❑

If yes, check appropriate box and explain below.

❑ Head	❑ Elbow	❑ Hip
❑ Neck	❑ Forearm	❑ Thigh
❑ Back	❑ Wrist	❑ Knee
❑ Chest	❑ Hand	❑ Shin/calf
❑ Shoulder	❑ Finger	❑ Ankle
❑ Upper arm		❑ Foot

13. Do you want to weigh more or less than you do now?	❑	❑
Do you lose weight regularly to meet weight requirements for your sport?	❑	❑
14. Do you feel stressed out?	❑	❑

15. Record the year of your most recent immunizations (shots) for: (if unknown put ? in space)
Tetanus: _____ Measles: _____
Hepatitis B: _____ Chickenpox: _____

FEMALES ONLY	XXXXXXXX	
16. When was your first menstrual period?	❑	❑
When was your most recent menstrual period?	❑	❑
How much time do you usually have from the start of one period to the start of another?	❑	❑
How many periods have you had in the last year?	❑	❑
What was the longest time between periods in the last year?	❑	❑

Explain "Yes" answers here: _____

_____

_____

_____

_____

_____

Signature of athlete: _____ Signature of parent/guardian: _____Date:_____

SPORTS PREPARTICIPATION PHYSICAL EXAM

Name: _____ Date of birth:_____

Height:_____Weight: _____ % Body fat (optional): _____ Pulse:_____ BP ____/____ (____/____, ____/____)

Vision R 20/____ L 20/____ Corrected: ❑YES ❑NO Pupils: ❑Equal ❑Unequal

PHYSICAL EXAM

	NORMAL	SKIPPED	ABNORMAL FINDINGS	INITIALS*
MEDICAL				
Appearance	❑	❑		
Eyes/Ears/Nose/Throat	❑	❑		
Lymph Nodes	❑	❑		
Heart	❑	❑		
Pulses	❑	❑		
Lungs	❑	❑		
Abdomen	❑	❑		
Genitalia (males only)	❑	❑		
Skin	❑	❑		
MUSCULOSKELETAL				
Neck	❑	❑		
Back	❑	❑		
Shoulder/arm	❑	❑		
Elbow/forearm	❑	❑		
Wrist/hand	❑	❑		
Hip/thigh	❑	❑		
Knee	❑	❑		
Leg/ankle	❑	❑		
Foot	❑	❑		

* Station-based examination only

CLEARANCE

❑ Cleared for unrestricted participate / play.

❑ Cleared after completing evaluation/rehabilitation for:_____

_____

_____

❑ Not cleared for:_____ Reason:_____

_____

_____

Recommendations: _____

_____

_____

_____

Signature of physician _____

CENTER
For Sports Medicine & Orthopaedics