

Sports Preparticipation/General Physical Exam Form

Name _____ Date of birth _____

Height ____ Weight ____ % Body fat (optional) ____ Pulse ____ BP ____

Vision R 20/ ____ L 20/ ____ Corrected: Y N UA ____ Hearing R

 L

Follow-up Questions on More Sensitive Issues

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel safe? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 30 days, did you use chewing tobacco, snuff or dip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 30 days, have you had at least 1 drink of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken any supplements to help you gain or lose weight Or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc | <input type="checkbox"/> | <input type="checkbox"/> |

Meds: _____

Allergies: _____

Activities: _____

	Normal	Abnormal Findings	Deferred
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Activity Recommendations: No restrictions Restrictions

Other Diagnoses: _____

Name of physician (print/type) _____ Date: _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

DATE OF EXAM _____

Name _____		Sex _____	Age _____	Date of birth _____
Grade _____	School _____	Sport(s) _____		
Address _____		Phone _____		
Personal physician _____				
<i>In case of emergency, contact</i>				
Name _____	Relationship _____	Phone (H) _____	(W) _____	

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

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart infection | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis, that caused you to miss a practice or game? If yes, circle the affected area below: | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones, or dislocated joints? If yes circle below: | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? If yes circle below: | <input type="checkbox"/> | <input type="checkbox"/> |

22. Do you regularly use a brace or assistive device?
23. Has a doctor ever told you that you have asthma or allergies?
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?
25. Is there anyone in your family who has asthma?
26. Have you ever used an inhaler or taken asthma medicine?
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
28. Have you had infectious mononucleosis (mono) within last month?
29. Do you have any rashes, pressure sores, or other skin problems?
30. Have you had a herpes skin infection?
31. Have you ever had a head injury or concussion?
32. Have you been hit in the head and been confused or lost your memory?
33. Have you ever had a seizure?
34. Do you have headaches with exercise?
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
36. Have you ever been unable to move your arms or legs after being hit or falling?
37. When exercising in the heat, do you have severe muscle cramps or become ill?
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
39. Have you had any problems with your eyes or vision?
40. Do you wear glasses or contact lenses?
41. Do you wear protective eyewear, such as goggles or a face shield?
42. Are you happy with your weight?
43. Are you trying to gain or lose weight?
44. Has anyone recommended you change your weight or eating habits?
45. Do you limit or carefully control what you eat?
46. Do you have any concerns that you would like to discuss with a doctor?

FEMALES ONLY

47. Have you ever had a menstrual period?
48. How old were you when you had your first menstrual period? _____
49. How many periods have you had in the last year? _____

Immunizations	Year
Tetanus	_____
MMR	_____
Hep A	_____
Meningococcal	_____
Tdap	_____

Signature of athlete _____
 Signature of parent/guardian _____
 Date _____

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

- | | Yes | No |
|--|--------------------------|--------------------------|
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |

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