Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name ___________________________________________ Date of birth ____________________________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   • Do you feel stressed out or under a lot of pressure?
   • Do you ever feel sad, hopeless, depressed, or anxious?
   • Do you feel safe at your home or residence?
   • Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   • During the past 30 days, did you use chewing tobacco, snuff, or dip?
   • Do you drink alcohol or use any other drugs?
   • Have you ever taken anabolic steroids or used any other performance supplement?
   • Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   • Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION

Height _______________ Weight ____________________ □ Male □ Female
BP __________________/ ___________________ Pulse ____________________ Vision R 20/ ____________________
L 20/ ____________________ □ Corrected □ Y □ N

MEDICAL

NORMAl

ABNORMAL FINDINGS

Appearance
   • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

Eyes/ears/nose/throat
   • Pupils equal
   • Hearing

Lymph nodes

Heart *
   • Murmurs (auscultation standing, supine, +/- Valsalva)
   • Location of point of maximal impulse (PMI)

Pulses
   • Simultaneous femoral and radial pulses

Lungs

Abdomen

Genitourinary (males only) *

Skin
   • HSV, lesions suggestive of MRSA, tinea corporis

Neurologic *

MUSCULOSKELETAL

Neck

Back

Shoulder/arm

Elbow/forearm

Wrist/hand/fingers

Hip/thigh

Knee

Leg/ankle

Foot/toes

Functional
   • Duck-walk, single leg hop

<Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider (b) exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ___________________________________________________________

☐ Not cleared
   ☐ Pending further evaluation
   ☐ For any sports
   ☐ For certain sports ___________________________________________________________

Reason ___________________________________________________________

Recommendations ___________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________________________________________ Date ____________________

Address ____________________________________________________________________________ Phone ____________________________

Signature of physician ___________________________________________________________________, MD or DO


HE0393 9-26E1/0410
# Preparticipation Physical Evaluation

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Name</th>
<th>Date of birth</th>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
</table>

## Medicines and Allergies

Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Pollens</th>
<th>Food</th>
<th>Stinging Insects</th>
</tr>
</thead>
</table>

## Do you have any allergies?  □ Yes  □ No  If yes, please identify specific allergy below.

| □ Medicines | □ Pollens | □ Food |

## Explain “Yes” answers here. Circle questions you don’t know the answers to.

### GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason?  □ Yes  □ No
2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Anemia □ Diabetes □ Infections □ Other: 
3. Have you ever spent the night in the hospital?  □ Yes  □ No
4. Have you ever had surgery?  □ Yes  □ No

### HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out DURING or AFTER exercise?  □ Yes  □ No
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?  □ Yes  □ No
7. Does your heart ever race or skip beats (irregular beats) during exercise?  □ Yes  □ No
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki disease □ Other: 
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)  □ Yes  □ No
10. Do you get lightheaded or feel more short of breath than expected during exercise?  □ Yes  □ No
11. Have you ever had an unexplained seizure?  □ Yes  □ No
12. Do you get more tired or short of breath more quickly than your friends during exercise?  □ Yes  □ No

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?  □ Yes  □ No
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?  □ Yes  □ No
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?  □ Yes  □ No
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  □ Yes  □ No

### BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?  □ Yes  □ No
18. Have you ever had any broken or fractured bones or dislocated joints?  □ Yes  □ No
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?  □ Yes  □ No
20. Have you ever had a stress fracture?  □ Yes  □ No
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)  □ Yes  □ No
22. Do you regularly use a brace, orthotics, or other assistive device?  □ Yes  □ No
23. Do you have a bone, muscle, or joint injury that bothers you?  □ Yes  □ No
24. Do any of your joints become painful, swollen, feel warm, or look red?  □ Yes  □ No
25. Do you have any history of juvenile arthritis or connective tissue disease?  □ Yes  □ No

### MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?  □ Yes  □ No
27. Have you ever used an inhaler or taken asthma medicine?  □ Yes  □ No
28. Is there anyone in your family who has asthma?  □ Yes  □ No
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?  □ Yes  □ No
30. Do you have groin pain or a painful bulge or hernia in the groin area?  □ Yes  □ No
31. Have you had infectious mononucleosis (mona) within the last month?  □ Yes  □ No
32. Do you have any rashes, pressure sores, or other skin problems?  □ Yes  □ No
33. Have you had a herpes or MRSA skin infection?  □ Yes  □ No
34. Have you ever had a head injury or concussion?  □ Yes  □ No
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?  □ Yes  □ No
36. Do you have a history of seizure disorder?  □ Yes  □ No
37. Do you have headaches with exercise?  □ Yes  □ No
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  □ Yes  □ No
39. Have you ever been unable to move your arms or legs after being hit or falling?  □ Yes  □ No
40. Have you ever become ill while exercising in the heat?  □ Yes  □ No
41. Do you get frequent muscle cramps when exercising?  □ Yes  □ No
42. Do you or someone in your family have sickle cell trait or disease?  □ Yes  □ No
43. Have you had any problems with your eyes or vision?  □ Yes  □ No
44. Have you had any eye injuries?  □ Yes  □ No
45. Do you wear glasses or contact lenses?  □ Yes  □ No
46. Do you wear protective eye wear, such as goggles or a face shield?  □ Yes  □ No
47. Do you worry about your weight?  □ Yes  □ No
48. Are you trying to or has anyone recommended that you gain or lose weight?  □ Yes  □ No
49. Are you on a special diet or do you avoid certain types of foods?  □ Yes  □ No
50. Have you ever had an eating disorder?  □ Yes  □ No
51. Do you have any concerns that you would like to discuss with a doctor?  □ Yes  □ No

### FE MALES ONLY

52. Have you ever had a menstrual period?  □ Yes  □ No
53. How old were you when you had your first menstrual period?  □ Yes  □ No
54. How many periods have you had in the last 12 months?  □ Yes  □ No

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

Signature of athlete: ___________________________  Signature of parent/guardian: ___________________________  Date: ___________________________

Preparticipation Physical Evaluation

CLEARANCE FORM

Name ____________________________     Sex □ M □ F     Age _______________     Date of birth _______________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _______________________________________________________________________________________________________________________________________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports

Reason _______________________________________________________________________________________________________________________________________________________

Recommendations _______________________________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________________________________________________________________________________ Date ________________

Address ______________________________________________________________________________________________________ Phone _________________________

Signature of physician _____________________________________________________________________________________________________, MD or DO

EMERGENCY INFORMATION

Allergies _______________________________________________________________________________________________________________________________________________________
Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ___________________________________________________________________________________

Name __________________________________________________________________________________________

Date of birth __________________________________________________________________________________

Sex ______ Age ______ Grade ______ School _____________________________ Sport(s) _______________________

1. Type of disability

2. Date of disability

3. Classification (if available)

4. Cause of disability (birth, disease, accident/trauma, other)

5. List the sports you are interested in playing

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<td>Yes</td>
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6. Do you regularly use a brace, assistive device, or prosthetic?

7. Do you use any special brace or assistive device for sports?

8. Do you have any rashes, pressure sores, or any other skin problems?

9. Do you have a hearing loss? Do you use a hearing aid?

10. Do you have a visual impairment?

11. Do you use any special devices for bowel or bladder function?

12. Do you have burning or discomfort when urinating?

13. Have you had autonomic dysreflexia?

14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?

15. Do you have muscle spasticity?

16. Do you have frequent seizures that cannot be controlled by medication?

Explain “yes” answers here

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Please indicate if you have ever had any of the following.

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<td>Yes</td>
<td>No</td>
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Atlantoaxial instability
X-ray evaluation for atlantoaxial instability
Dislocated joints (more than one)
Easy bleeding
Enlarged spleen
Hepatitis
Osteopenia or osteoporosis
Difficulty controlling bowel
Difficulty controlling bladder
Numbness or tingling in arms or hands
Numbness or tingling in legs or feet
Weakness in arms or hands
Weakness in legs or feet
Recent change in coordination
Recent change in ability to walk
Spina bifida
Latex allergy

Explain “yes” answers here

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

Signature of athlete ___________________________ Signature of parent/guardian ___________________________ Date ___________