PRE-PARTICIPATION PHYSICAL FORM - *MEDICAL HISTORY FORM*

DATE OF EXAM: ____/____/____

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.

Please *Circle* questions you don't know the answers to…

	YES	NO
1. Has a doctor over denied or restricted your participation in sports for any reason?	❑	❑
2. Do you have an ongoing medical condition (like diabetes or asthma)?	❑	❑
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	❑	❑
4. Do you have allergies to medicines, pollens, foods, or slinging insects?	❑	❑
5. Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6. Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	❑	❑
8. Does your heart race or skip beats during exercise?	❑	❑
9. Has a doctor ever told you that you have (check all that apply): ❑ High blood pressure ❑ Heart murmur ❑ High cholesterol ❑ Heart infection		
I0 Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	❑	❑
11 Has anyone in your family died for no apparent reason?	❑	❑
12 Does anyone in your family have a heart problem?	❑	❑
13 Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
14 Does anyone in you family have Marfan syndrome?	❑	❑
15 Have you ever spent the night in a hospital?	❑	❑
16 Have you ever had surgery?	❑	❑
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 affected area below:	❑	❑
18 Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	❑	❑
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	❑	❑

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

20 Have you ever had a stress fracture?	❑	❑
21 Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	❑	❑
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 the 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?	_____y/o	
49 How many periods have you had in the last 12 months?	_____	

Explain any "Yes" answers here:

_____

_____

_____

_____

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

PRE-PARTICIPATION PHYSICAL FORM - ***PHYSICIAN EXAM FORM***

Name: _____ Date of birth: _____

Height:_____ Weight: _____ % Body fat (*optional*): _____ Pulse: _____ BP: ____/____ (____/____)

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

EMERGENCY INFORMATION:

Drug Allergies: _____

Other Information: _____

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

* Station-based or Multiple examiners only ** Having a third party present is recommended for the genitourinary exam

❑ **Cleared** without restriction

❑ **Cleared with recommendations** for further evaluation or treatment for: _____

_____

_____

❑ **Not cleared for:** ❑All Sports, ❑Certain Sports:_____ Reason: _____

_____

_____

Recommendations: _____

_____

_____

Name of Physician (Print / Type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____ MD/DO

PRE-PARTICIPATION PHYSICAL FORM – ***SUPPLEMENTAL SCREEN***

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

Follow-Up Questions on More Sensitive Issues (Physician Only)	**Yes**	**No**
1) Do you feel stressed out or under a lot of pressure?	❑	❑
2) Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	❑	❑
3) Do you feel safe?	❑	❑
4) Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	❑	❑
5) During the past 30 days, did you use chewing tobacco, snuff, or dip?	❑	❑
6) During the pant 30 days, have you had at least I drink of alcohol?	❑	❑
7) Have you over taken steroid pills or shots without a doctor's prescription?	❑	❑
8) Have you ever taken any supplements to help you gain or lose weight or improve your performance?	❑	❑
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.	❑	❑

Notes: _____

_____

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