# Pre-participation Physical Evaluation

To be filled out by Physician

Last Name ___________________ First Name ___________________ Date of Birth _______ Grade _______

Gender _______ Height _______ Weight _______ %Body Fat (optional) _______ Pulse _______

BP _______/_____/_____ Vision R 20/_____/ L 20/_____/ Corrected: Y N Pupils: Equal ______ Unequal ______

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
<th>INITIALS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
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<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>Heart</td>
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<td>Murmurs</td>
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<td>Pulses</td>
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<td>Lungs</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Genitourinary (males only)*</td>
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<td></td>
<td></td>
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<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 | | | |

Notes: ________________________________________________________________

This athlete is:

- [ ] Cleared without restriction for ALL SPORTS
- [ ] Cleared without restriction for certain sports ________________________ 
- [ ] Cleared, with recommendations for further evaluation or treatment for: ________________________ 
- [ ] Not Cleared - Reason: ________________________

Recommendations: ______________________________________________________

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<thead>
<tr>
<th>EMERGENCY INFORMATION</th>
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<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td>Physical Date</td>
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<tr>
<td>Name of physician (print/type)</td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>Address</td>
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<td>Phone</td>
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I have completed the Pre-participation Physical Evaluation and reviewed the Physical History Form.

Signature of Physician ___________________, MD or DO (Cannot accept physical done by a Chiropractor)

Place Address/Facility stamp here (physical will NOT be accepted without stamp)
Preparticipation Physical Evaluation

Date of Exam ____________

Mandatory

Revised 7/1105

In case of emergency, contact:

Personal Physician

Name ________ __ Relationship ______ Phone (H) _______ Phone(W) _____

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. Has a doctor ever ordered a test for your heart (for example: ECG, echocardiogram)?
   - Yes
   - No

10. Has a doctor ever ordered a test for your heart with a heart murmur
   - 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. Does anyone in your family have a heart infection?
    - Yes
    - No

14. Does anyone in your family have Marfan syndrome?
    - Yes
    - No

15. Have you ever been hit in the head and been confused or lost your memory?
    - 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? If yes, circle affected area below:
    - Yes
     - No

18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:
    - 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? If yes, circle below:
    - 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 had a head injury or concussion?
    - Yes
    - No

32. Have you been told that you have or have you had a hernia, an iliac crest, or any other organ?
    - Yes
    - No

33. Have you been told that you have or have you had a hernia, an iliac crest, or any other organ?
    - Yes
    - No

34. Have you ever had any rashes, pressure sores, or other skin problems?
    - 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

Females Only

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

Explain "Yes" answers here:

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 ____________