Preparticipation Physical Evaluation
HISTORY FORM

Date of Exam

Name _____________________________ Date of Birth

Sex _____ Age _____ Grade _____ School _____ Sports(s) _____

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

Do you have any allergies? _____ Yes _____ No _____ If yes, please identify specific allergy below:

☐ Medicines _____ ☐ Pollens _____ ☐ Food _____ ☐ Stinging Insects

Explain "Yes" answers below. 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 yes, please specify below:
   ☐ Asthma ☐ Arthritis ☐ Diabetes ☐ Injuries
   ☐ 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 chest pain, tightness, or pressure in your chest during exercise? _____ Yes _____ No
7. Does your heart ever race or skip beats (irregular heart rate) 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
   ☐ Chest pain
   ☐ Heart murmur
   ☐ Heart problems
   ☐ Kawasaki disease
   ☐ Other:
9. Has a doctor ever advised you to limit your physical activity? (For example, SCAVENGER bronchocardiac)
10. Do you get lightheaded or feel more short of breath than usual during exercise? _____ Yes _____ No
11. Have you ever had an unexplained heart murmur? _____ Yes _____ No
12. Do you get more short of breath on a regular basis than your friends during exercise? _____ Yes _____ No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY
13. Has anyone in the family been diagnosed with heart disease? _____ Yes _____ No
14. Does anyone in the family have hyperlipidemia (elevated cholesterol)? _____ Yes _____ No
15. Does anyone in the family have hypertension (high blood pressure)? _____ Yes _____ No
16. Does anyone in the family have a heart problem, aneurysm, or implanted defibrillator? _____ Yes _____ No
17. Has anyone in the family had unexplained fainting, unexplained seizures, or near drowning? _____ Yes _____ No

BONE AND JOINT QUESTIONS
18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or a game? _____ Yes _____ No
19. Have you ever had any broken or fractured bones or dislocated joints? _____ Yes _____ No
20. Have you ever had a stress fracture? _____ Yes _____ No
21. Have you ever fallen and have you had or have you been told you had an x-ray for neck instability or thoracic 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, warm, or look red? _____ Yes _____ No
25. Do you have any history of juvenile arthritis or connective tissue disease? _____ Yes _____ No

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? _____ Yes _____ No
27. Have you ever taken an inhaler or taken asthma medicine? _____ Yes _____ No
28. Is there anyone in your family who has asthma? _____ Yes _____ No
29. Have you ever been told you have a kidney, eye, or heart condition? (check all that apply):
   ☐ Kidney problems
   ☐ Heart condition
   ☐ Other:
30. Have you ever had a heart attack or heart disease? _____ Yes _____ No
31. Have you had an infectious mononucleosis (mononucleosis) within the last month? _____ Yes _____ No
32. Do you have any rashes, pressure sores, or other skin problems? _____ Yes _____ No
33. Have you ever had an earache or MRS skin infection? _____ Yes _____ No
34. Have you ever had a head injury or concussion? _____ Yes _____ No
35. Have you ever had a blow to the head that caused confusion, prolonged headache, or memory problems? _____ Yes _____ No
36. Have you had a history of seizures? _____ 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 a cardiac heart condition? _____ 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 use protective eye wear, such as goggles or a face shield? _____ Yes _____ No
47. Do you take any medications for allergies? _____ Yes _____ No
48. Are you taking any medications that affect your heart or blood pressure? _____ Yes _____ No
49. Do you have a history of heart disease? _____ 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

FEMALES 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

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 _____________________________ Date _____________

Signature of parent/guardian _____________________________ Date _____________

### Preparticipation Physical Evaluation

**The Athlete with Special Needs: Supplemental History Form**

**Date of Exam:**

**Name:**

**Sex:**

**Age:**

**Grade:**

**School:**

**Sport(s):**

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<table>
<thead>
<tr>
<th>1. Type of disability</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Date of disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Classification (if available)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Cause of disability (birth, disease, accident/trama, other)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. List the sports you are interested in playing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 6. Do you regularly use a brace, assistive device, or prosthesis? | Yes | No |
| 7. Do you use any special braces or assistive device for sports? |     |    |
| 8. Do you have any rash, 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 atraumatic dystrophy? |     |    |
| 14. Have you ever been diagnosed with a heat-related (hypothermia) 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:**

---

**Please indicate if you have ever had any of the following:**

| Ataxia or ataxia-like instability | Yes | No |
| X-ray evaluation for ataxia or ataxia-like instability |     |    |
| Dyscontrol joints (more than one) |     |    |
| Easy bleeding |     |    |
| Enlarged spleen |     |    |
| Heredity |     |    |
| 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 |     |    |
| Scoliosis |     |    |
| Leukemia |     |    |

**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:**

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# Preparticipation Physical Evaluation

## Physical Examination Form

### 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 used cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Have you ever taken any other performance supplements (e.g., creatine, caffeine)?
   - Have you ever taken any medications 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

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>/</td>
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<tr>
<td>Pulse</td>
<td></td>
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<tr>
<td>Vision</td>
<td></td>
<td>L</td>
<td>20/</td>
</tr>
<tr>
<td>Corr.</td>
<td></td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

#### Medical

- **Appearance**
  - **Muscle atrophy, hirsutism, obesity, pectus excavatum, anorexia, deformities, arrhythmias, club feet, height, weight, blood pressure, hyperactivity, impetigo, UV, scoliosis**

#### Eyes/ears/nose/throat

- Pupils
- Hearing
- Lymph nodes

#### Heart

- Murmurs
- Aortic stenosis
- Location of point at maximal impotence (PIM)

#### Lungs

- Breath sounds
- Radiological eval.

#### Abdomen

- Gastrointestinal (GI) tract
- Liver size, tenderness

#### Skin

- 10+ lesions suggestive of MI, connective tissue disease of joints

#### Neurological

- CNS evaluation
- Sensory impairment

#### Musculoskeletal

- Neck
- Back
- Shoulder
- Elbow/forearm
- Wrist/hand/fingers
- Hip/leg
- Knee
- Ankle/foot
- Follow-up
- Quick walk, single leg hop

#### Date of Exam:

- [ ] Cleared for all sports without restriction
- [ ] Cleared for all sports without restrictions with recommendations for further evaluation or treatment for

- [ ] Not cleared
  - [ ] Pending further evaluation
  - [ ] For any sports
  - [ ] For certain sports

#### 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 any office and can be made available to the school at the request of the parent. 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) ____________________________
Address ____________________________ Date ____________
Signature of physician ____________________________

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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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Other Information

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________