# 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.)

Date of Exam  
Name  
Sex  Age  Grade  School  Sport(s)  Date of birth  

<table>
<thead>
<tr>
<th>Foods and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any allergies? Yes  No  If yes, please identify specific allergy below.</td>
</tr>
<tr>
<td>Medicines  Pollens  Food  Stinging Insects</td>
</tr>
</tbody>
</table>

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?  
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?  
4. Have you ever had surgery?  
5. Have you ever passed out or nearly passed out during or after exercise?  
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?  
7. Does your heart ever race or skip beats (irregular beats) during exercise?  
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:  
   - High blood pressure  
   - High cholesterol  
   - Kawasaki disease  
   - Other:  
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)  
10. Do you get lightheaded or feel short of breath more than expected during exercise?  
11. Have you ever had an unexplained seizure?  
12. Do you get more tired or short of breath more quickly than your friends during exercise?  

### Heart Health Questions About You

13. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?  
14. Do you have a history of seizure disorder?  
15. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  
16. Have you ever been unable to move your arms or legs after being hit or falling?  
17. Have you ever become ill while exercising in the heat?  
18. Do you get frequent muscle cramps while exercising?  
19. Do you or someone in your family have sickle cell trait or disease?  
20. Have you ever had a heart infection?  
21. A heart murmur  
22. A heart murmur  
23. A heart infection  
24. A heart condition  
25. Kawasaki disease  
26. Has a doctor ever denied or restricted your participation in sports for any reason?  
27. Have you ever used a inhaler or taken asthma medicine?  
28. Is there anyone in your family who has asthma?  
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?  
30. Do you have groin pain or a painful bulge or hernia in the groin area?  
31. Do you have a heart condition?  
32. Do you have any rashes, pressure sores, or other skin problems?  
33. Have you ever had a head injury or concussion?  
34. Have you ever had a head injury or concussion?  
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?  
36. Do you have a history of seizure disorder?  
37. Do you have headaches with exercise?  
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  
39. Have you ever been unable to move your arms or legs after being hit or falling?  
40. Have you ever become ill while exercising in the heat?  
41. Do you get frequent muscle cramps while exercising?  
42. Do you or someone in your family have sickle cell trait or disease?  
43. Have you ever had a heart infection?  
44. A heart murmur  
45. A heart murmur  
46. A heart infection  
47. A heart condition  
48. A heart condition  
49. Kawasaki disease  
50. Kawasaki disease  
51. Kawasaki disease  
52. Kawasaki disease  
53. Kawasaki disease  
54. Kawasaki disease  

### Medical Questions

1. Do you have any history of juvenile arthritis or connective tissue disease?  
2. Do you have had a stress fracture?  
3. Have you ever had surgery?  
4. Have you ever had surgery?  
5. Have you ever had surgery?  
6. Have you ever had surgery?  
7. Have you ever had surgery?  
8. Have you ever had surgery?  
9. Have you ever had surgery?  
10. Have you ever had surgery?  
11. Have you ever had surgery?  
12. Have you ever had surgery?  
13. Have you ever had surgery?  
14. Have you ever had surgery?  
15. Have you ever had surgery?  
16. Have you ever had surgery?  
17. Have you ever had surgery?  
18. Have you ever had surgery?  
19. Have you ever had surgery?  
20. Have you ever had surgery?  
21. Have you ever had surgery?  
22. Have you ever had surgery?  
23. Have you ever had surgery?  
24. Have you ever had surgery?  
25. Have you ever had surgery?  
26. Have you ever had surgery?  
27. Have you ever had surgery?  
28. Have you ever had surgery?  
29. Have you ever had surgery?  
30. Have you ever had surgery?  
31. Have you ever had surgery?  
32. Have you ever had surgery?  
33. Have you ever had surgery?  
34. Have you ever had surgery?  
35. Have you ever had surgery?  
36. Have you ever had surgery?  
37. Have you ever had surgery?  
38. Have you ever had surgery?  
39. Have you ever had surgery?  
40. Have you ever had surgery?  
41. Have you ever had surgery?  
42. Have you ever had surgery?  
43. Have you ever had surgery?  
44. Have you ever had surgery?  
45. Have you ever had surgery?  
46. Have you ever had surgery?  
47. Have you ever had surgery?  
48. Have you ever had surgery?  
49. Have you ever had surgery?  
50. Have you ever had surgery?  
51. Have you ever had surgery?  
52. Have you ever had surgery?  
53. Have you ever had surgery?  
54. Have you ever had surgery?  

### Females Only

55. How old were you when you had your first menstrual period?  
56. How many periods have you had in the last 12 months?  

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  

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

6. Do you regularly use a brace, assistive device, or prosthesis? 
   Yes  No
7. Do you use any special brace or assistive device for sports? 
   Yes  No
8. Do you have any rashes, pressure sores, or any other skin problems? 
   Yes  No
9. Do you have a hearing loss? Do you use a hearing aid? 
   Yes  No
10. Do you have a visual impairment? 
    Yes  No
11. Do you use any special devices for bowel or bladder function? 
    Yes  No
12. Do you have burning or discomfort when urinating? 
    Yes  No
13. Have you had autonomic dysreflexia? 
    Yes  No
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? 
    Yes  No
15. Do you have muscle spasticity? 
    Yes  No
16. Do you have frequent seizures that cannot be controlled by medication? 
    Yes  No

Explain “yes” answers here

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

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

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 ____________________________
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

<table>
<thead>
<tr>
<th>Examination</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Male</td>
<td>☐ Female</td>
<td></td>
</tr>
<tr>
<td>BP / ( )</td>
<td>Pulse</td>
<td>Vision R 20/ L 20/</td>
</tr>
<tr>
<td>Corrected</td>
<td>☐ Y</td>
<td>☐ N</td>
</tr>
</tbody>
</table>

Medical

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Marfan Stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes/ears/nose/throat</td>
<td>□ Pupils equal</td>
</tr>
<tr>
<td>Heart</td>
<td>□ Murmurs (auscultation standing, supine, +/- Valsalva)</td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td>□ Simultaneous femoral and radial pulses</td>
</tr>
</tbody>
</table>

Abdomen

Genitourinary (males only)

Skin

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 (6) 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

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 ____________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________