

# Physical Examination Form

(Note: this form is to be filled out and signed by a parent/guardian **before** you see a physician)

Name (please print) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Exam \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines & Allergies:** Please list all of the prescriptions 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 -  Medicines  Pollens  Food  Stinging Insects  
Describe \_\_\_\_\_

General Questions	Y/N
1. Has a doctor ever denied or restricted your participation in sports for any reason?	
1. Do you have any ongoing medical conditions? If so, Please Identify <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other _____	
2. Have you ever had surgery?	
HEART HEALTH QUESTIONS ABOUT YOU	Y/N
3. Have you u ever passed out DURING or After Exercise?	
4. Have you ever had discomfort pain, tightness, or pressure in your chest during exercise?	
5. Does your heart ever race or skip beats (irregular beats) during exercise?	
6. Has a Doctor ever told you have the following conditions, check all that apply : <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart Infection <input type="checkbox"/> Kawasaki disease Other _____	
7. Has a doctor ever ordered a test for your heart?( EKG, ECG, echocardiogram)?	
8. Do you get lightheaded or feel more short of breath than expected during exercise?	
9. Have you ever had an unexpected seizure?	
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Y/N
10. Has any Family member or relative died or have heart problems or unexpected sudden death (before 50) including drowning, car accident, or sudden infant death syndrome?	
11. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, short QT syndrome, Brugada syndrome, or Catecholaminergic polymorphic ventricular tachycardia?	
12. Does anyone in your family have a heart problem, pacemaker, or implemented defibrillator?	
13. Has anyone in your family had unexpected fainting, unexplained seizures, or near drowning?	
Medical Questions	Y/N
14. Do you cough, wheeze, or have difficulty breathing during or after exercise?	
15. Have you ever used an inhaler or taken asthma medicine?	
16. Is there anyone in your family who has asthma?	
17. Were you Born without or are you missing a kidney, eye, testicle (males), your spleen, or any other organ?	
18. Do you have groin pain or painful bulge or hernia in the groin area?	
19. Have you had infectious mononucleosis (mono) within the last month?	
20. Have you have any rashes, pressure sores, or any other skin problems?	
21. Have you had herpes or MRSA skin infection?	
22. Have you ever had a head injury or concussion?	
23. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	
24. Have you ever been unable to move your arms or legs after being hit or fallen?	
25. Have you ever become ill while exercising in the heat?	
26. Do you get frequent muscle cramps when exercising?	
27. Do you or someone in your family have sickle cell trait or disease?	
28. Have you had any problems with your eyes or vision?	
29. Have you had any eye injuries?	
30. Have you ever had an eating disorder?	
31. Do you have any concerns that you would like to discuss with a doctor?	

Females Only	Y	N
33. Have you ever had a menstrual period?		
34. How old were you when you had your first menstrual period?		
35. How many periods have you had in last 12 months?		

Examination	
Height: _____	Weight: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
BP: _____ / _____	Pulse: _____ Vision: R 20/____ L 20/____ Corrected Y N

Medical	Normal	*History/Abnormal Findings
Appearance: *Marfan Stigmata (Kyphoscoliosis, high-arched palate, pectus excavatum, arachondactylism 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 (ROM)		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional - Duck-walk, single leg hop		

\*Explain any previous musculoskeletal injuries

Cleared for all sports without restriction

Cleared for all sports with the following restrictions/recommendations:

Not Clear

Signature parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

I have examined the above names student and completed the pre-participation physical evaluation

Name of physician \_\_\_\_\_ Date \_\_\_\_\_

Signature of physician (MD or DO only) \_\_\_\_\_ Physician Stamp: \_\_\_\_\_