PHYSICAL EVALUATION

Date of Exam: ______________________

Name: ____ Gender: ____ Age: _____ Date of Birth: ___________________

Grade: _____ School: ___________________________ Sport(s): ____

Address: ____Phone:___________________________

Personal Physician: ______________________________Phone:____

In Case of Emergency Contact:

Name: _________________________ Relationship: ___________________ Phone (H):_____________ (W) ___________________
(C) ___________________

Please answer all questions below. Explain any "Yes" Answer in the space provided and Circle any question you don't know the answer 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, asthma, or high blood pressure? Yes No
3. Do you have any allergies to medications, pollens, foods, or stinging insects? Yes No
4. Have you ever passed out or nearly passed out during or after exercise? Yes No
5. Have you ever had discomfort, pain, or pressure in your chest during exercise? Yes No
6. Does your heart race or skip beats during exercise? Yes No
7. Has a doctor ever ordered a test for your heart called an EKG? Yes No
8. Has anyone in your family died of a heart problem before age 50? Yes No
9. Does anyone in your family have Marfan's Syndrome? Yes No
10. Have you ever spent the night in the hospital? Yes No
11. Have you ever had surgery? Yes No
12. Have you ever had an injury that caused you to miss a practice or game? Yes No
13. Have you ever had a broken or dislocated bone? Yes No
14. Do you regularly use a brace or other assistive device? Yes No
15. Has a doctor ever told you that you have asthma or allergies? Yes No
16. Do you cough, wheeze, or have difficulty breathing during exercise? Yes No
17. Have you ever used an inhaler or taken asthma medicines? Yes No
18. Were you born without or are you missing a kidney, eye, a testicle or any other organ? Yes No
19. Have you had infectious mononucleosis (mono) in the last month? Yes No
20. Do you have any rashes or other skin problems? Yes No
21. Have you had a herpes skin infection? Yes No
22. Have you ever had a concussion? Yes No
23. Have you ever hit your head and been confused or lost your memory? Yes No
24. Do you have headaches with exercise? Yes No
25. Have you ever had weakness, numbness or tingling after being hit or falling? Yes No
26. Have you ever had a seizure? Yes No
27. When exercising in the heat, do you have muscle cramps and become ill? Yes No
28. Has a doctor told you or anyone in your family that they have sickle cell trait or sickle cell disease? Yes No
29. Have you had any problem with your eyes or vision? Yes No

MEDICATIONS:

1. ______________________________
2. ______________________________
3. _____________________________
4. _____________________________

ALLERGIES:

1. _______________________________
2. _______________________________
3. _______________________________

30. Do you wear glasses or contacts? Yes No

31. Are you happy with your weight? Yes No

FEMALES ONLY

32. Have you ever had a menstrual period? Yes No

33. How old were you when you had your first period? ________________

Explain any "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: ______________________________

Athletic Pre-participation Physical Evaluation

Name____ Date of Birth: _________________________

Height: ___________ Weight: _________ BMI: _______ Pulse: _______ BP: ______/_______

Vision: R 20/____, L 20/_____ Corrected: Y / N Pupils: Equal______ or Unequal________ Allergies_____________

	NORMAL	ABNORMAL	INTITIALS
GENERAL			
General Appearance			
HEENT			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
GU (males only)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulders/Arms			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Pre-participation Physical Evaluation Clearance

Name of Athlete: ____

Birthdate: ____

Grade: ____

School: ____

☐ ❒ Athlete is cleared without restrictions.

☐ ❒ Athlete is cleared with the following restrictions:

____

____

____

____

____

☐ ❒ Athlete is not cleared to participate

Name of Physician: ____ M.D. or D.O.

Address ____ Phone: _________________

Signature of Physician ____________________________________ Date: ___________________