In addition to this form, please be sure to complete all other forms available through FinalForms.

PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name: _____ Birth Date: _____ Exam Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Sport: _____

HISTORY

		Y	N	
1.	a.	☐	☐	Have you had any illness/injury recently, or do you have an illness/injury now?
	b.	☐	☐	Have you had a medical problem, illness or injury since your last exam?
	c.	☐	☐	Do you have any chronic or recurrent illness?
	d.	☐	☐	Have you ever had any illness lasting more than a week?
	e.	☐	☐	Have you ever been hospitalized overnight?
	f.	☐	☐	Have you had any surgery other than tonsillectomy?
	g.	☐	☐	Have you ever had any injuries requiring treatment by a physician?
	h.	☐	☐	Do you have any organ missing other that tonsils (appendix, eye, kidney, testicle, etc)?
2.		☐	☐	Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)?
3.		☐	☐	Do you have ANY allergies (medicines, bees, foods, or other factors)?
4.	a.	☐	☐	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
	b.	☐	☐	Do you tire more easily or quickly than your friends during exercise?
	c.	☐	☐	Have you ever had any problem with your blood pressure or your heart?
	d.	☐	☐	Have any close relatives had heart problems, heart attack or sudden death before they were age 50?
5.		☐	☐	Do you have any skin problems (acne, itching, rashes, etc)?
6.	a.	☐	☐	Have you ever had fainting, convulsions, seizures or severe dizziness?
	b.	☐	☐	Do you have frequent severe headaches?
	c.	☐	☐	Have you ever had a "stinger" or "burner" or "pinched nerve"?
	d.	☐	☐	Have you ever been "knocked out" or "passed out"?
	e.	☐	☐	Have you ever had a neck or head injury.
7.		☐	☐	Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
8.		☐	☐	Have you had asthma, or trouble breathing, or cough during or after exercise?
9.	a.	☐	☐	Do you wear eyeglasses, contact lenses or protective eye wear?
	b.	☐	☐	Have you had any problem with your eyes or vision?
10.		☐	☐	Do you wear any dental appliance such as braces, bridge, plate or retainer?
11.	a.	☐	☐	Have you ever had a knee injury?
	b.	☐	☐	Have you ever had an ankle injury?
	c.	☐	☐	Have you ever injured any other joint (shoulder, wrist, fingers, etc)?
	d.	☐	☐	Have you ever had a broken bone (fracture)?
	e.	☐	☐	Have you ever had a cast, splint, or had to use crutches?
	f.	☐	☐	Must you use special equipment for competition (pads, braces, neck roll, etc.)?
12.		☐	☐	Has it been more than 5 years since your last tetanus booster shot?
13.		☐	☐	Are you worried about your weight?
14.		☐	☐	FEMALES: Have you any menstrual problems?
15.		☐	☐	Have you any medical concerns about participating in your sport?

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):

_____

_____

_____

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PHYSICAL EXAMINATION

STUDENT NAME: _____

Age: _____ Pulse: _____

Height: _____ Blood Pressure: _____

Weight: _____ Visual Acuity: Left 20/ ____
Right 20/ ____

Optional

Urinalysis:

Body Fat %

HCT:

EST VO2 Max:

Audiometry:

Normal			Abnormal	
☐	1.	Head	☐	_____
☐	2.	Eyes (pupils), ENT	☐	_____
☐	3.	Teeth	☐	_____
☐	4.	Chest	☐	_____
☐	5.	Lungs	☐	_____
☐	6.	Heart	☐	_____
☐	7.	Abdomen	☐	_____
☐	8.	Genitalia	☐	_____
☐	9.	Neurologic	☐	_____
☐	10.	Skin	☐	_____
☐	11.	Physical Maturity	☐	_____
☐	12.	Spine, Back	☐	_____
☐	13.	Shoulders, Upper Extremities	☐	_____
☐	14.	Lower Extremities	☐	_____

Assessment: ☐ Full Participation
☐ Limited participation (describe limitations, restrictions):

_____
_____

☐ Participation contraindicated (list reasons):

_____
_____

Recommendations (equipment, taping, rehabilitation, etc.):

_____
_____

EXAMINER'S PHONE: ( ) _____ EXAMINER'S SIGNATURE: _____

EXAM DATE: _____ PRINT EXAMINER'S NAME: _____
CIRCLE ONE: MD PA ARNP ND DO

Revision Date: April 2012