HAMILTON HIGH SCHOOL
Preparticipation Physical Evaluation

Date: _____

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

Grade: _____ Sport(s) _____ Personal Physician: _____

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	❑	❑
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	❑	❑
3.	Are you currently taking any prescriptions or nonprescription (over the counter) medicine or pills?	❑	❑
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	❑	❑
5.	Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6.	Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7.	Have you ever had discomfort, pain or pressure in your chest during exercise?	❑	❑
8.	Does your heart race or skip beats during exercise?	❑	❑
9.	Has a doctor ever told you that you have (check all that apply) high Blood pressure	❑	❑
10.	Has a doctor ever ordered a test for your heart? ECG, echocardiogram	❑	❑
11.	Has anyone in your family died for no apparent reason?	❑	❑
12.	Does anyone in your family have a hearing problem?	❑	❑
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
14.	Does anyone in your family have Marfan Syndrome?	❑	❑
15.	Have you ever spent the night in a hospital?	❑	❑
16.	Have you ever had surgery?	❑	❑
17.	Have you ever had an injury, like sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, write down: _____	❑	❑
18.	Have you ever had any broken or fractured bones or dislocated joints? If yes, write down: _____	❑	❑
19.	Have you had a one or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? If yes, write down: _____	❑	❑
20.	Have you ever had a stress fracture?	❑	❑
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	❑	❑
22.	Do you regularly use a brace or assistive device?	❑	❑
23.	Has a doctor ever told ever told you that you have Asthma or allergies?	❑	❑
24.	Do you have a hearing problem or wear a hearing device?	❑	❑
25.	Do you take medication?	❑	❑
26.	Is there anyone in your family who has asthma?	❑	❑
27.	Is there anyone in your family who has asthma?	❑	❑
28.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	❑	❑
29.	Have you ever used an inhaler or taken asthma medicine?	❑	❑
30.	Have you had infectious mononucleosis (mono) within the last month?	❑	❑
31.	Do you have any rashes, pressure sores, or other skin problems?	❑	❑
32.	Have you had herpes skin infection?	❑	❑
33.	Have you ever had a head injury or concussion?	❑	❑
34.	Have you been hit in the head and been confused or lost your memory?	❑	❑
35.	Have you ever had a seizure?	❑	❑
36.	Do you have headaches with exercise?	❑	❑
37.	Have you ever had numbness, tingling, or weakness in your arms?	❑	❑
38.	Have you ever been unable to move your arms or legs after being hit or falling?	❑	❑
39.	When exercising in the heat, do you have severe muscle cramps or become ill?	❑	❑
40.	Has a doctor told you that you or someone in your family has sickle cell traits or sickle cell disease?	❑	❑
41.	Have you had any problems with your eyes or vision?	❑	❑
42.	Do you wear glasses or contact lenses?	❑	❑
43.	Do you wear protective eyewear, such as goggles or a face shield?	❑	❑
44.	Are you happy with your weight?	❑	❑
45.	Are you trying to gain or lose weight?	❑	❑
46.	Has anyone recommended you change your weight or eating habits?	❑	❑
47.	Do you limit or carefully control what you eat?	❑	❑
48.	Do you have any concerns that you would like to discuss with a doctor?	❑	❑
	FEMALES ONLY	❑	❑
49.	Have you ever had a menstrual period?	❑	❑
50.	How old were you when you had your first menstrual period? _____	❑	❑
51.	How many periods have you had in the last 12 months? ____	❑	❑

Explain Yes answers:

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete Signature: _____ Parent/Guardian Signature: _____

Physical Examination Form
REQUIRED IF PLAYING HIGH SCHOOL SPORTS

Date of Examination: _____

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ % Body Fat (Optional) _____ Pulse_____ BP ____/____ (____/____, ____/____)

Vision: R 20/_____ L 20/_____ Corrected: Yes No Pupils: Equal _____ Unequal_____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses Lungs			
Abdomen			
Genitourinary (Males Only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thighs			
Knee			
Leg/Ankle/Foot/Toes			

*Multiple-examiner set-up only. +Having a third-party present is recommended for the genitourinary examination

❑ Cleared without restrictions

❑ Cleared with recommendations for further evaluation or treatment for: _____

❑ NOT CLEARED FOR:
- ❑ All Sports
- ❑ Certain Sports: _____
- Reason: _____

Recommendations: _____

_____

_____

Name of Physician: _____

Address:

_____

_____

Phone #: _____

Signature of Physician: _____