

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

### Follow-Up Questions on More Sensitive Issues

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel safe?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 30 days, did you use chewing tobacco, snuff, or dip?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 30 days, have you had a least 1 drink of alcohol?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Questions from the Youth Risk Behavior Survey ( <a href="http://www.cdc.gov/HealthyYouth/yrbs/index.htm">http://www.cdc.gov/HealthyYouth/yrbs/index.htm</a> ) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc. | <input type="checkbox"/> | <input type="checkbox"/> |

Notes: \_\_\_\_\_

|                             | NORMAL | ABNORMAL FINDINGS | INITIALS |
|-----------------------------|--------|-------------------|----------|
| <b>MEDICAL</b>              |        |                   |          |
| Appearance                  |        |                   |          |
| Eyes/Ears/Nose/Throat       |        |                   |          |
| Hearing                     |        |                   |          |
| Lymph nodes                 |        |                   |          |
| Heart                       |        |                   |          |
| Murmurs                     |        |                   |          |
| Pulses                      |        |                   |          |
| Lungs                       |        |                   |          |
| Abdomen                     |        |                   |          |
| Genitourinary (males only)* |        |                   |          |
| Skin                        |        |                   |          |
| <b>MUSCULOSKELETAL</b>      |        |                   |          |
| Neck                        |        |                   |          |
| Back                        |        |                   |          |
| Shoulder/arm                |        |                   |          |
| Elbow/forearm               |        |                   |          |
| Wrist/hand/fingers          |        |                   |          |
| Hip/thigh                   |        |                   |          |
| Knee                        |        |                   |          |
| Leg/ankle                   |        |                   |          |
| Foot/toes                   |        |                   |          |

\*Multiple-examiner set-up only.

\*Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_

Not cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_  
Recommendations: \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

**IMMUNIZATIONS** (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

- Up to date (see attached documentation)
- Not up to date Specify \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_

Not cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_  
Recommendations: \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

**IMMUNIZATIONS** (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

- Up to date (see attached documentation)
- Not up to date Specify \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO