

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

PART 1: Personal Information (to be completed by student and parents or guardian) PRINT

Last Name _____ First Name _____

Phone# _____ Birth Date _____

Emergency Contact _____ Phone # _____

Grade _____ Sport(s) _____

Part 2: Health History (Must be completed prior to the examination). Explain all "yes" answers in the space provided below

	Yes / No		Yes / No
1. Have you had a medical problem or injury since your last physical evaluation?	<input type="checkbox"/> <input type="checkbox"/>	19. Do use an inhaler or take Asthma medication?	<input type="checkbox"/> <input type="checkbox"/>
2. Are you presently under a doctor's care?	<input type="checkbox"/> <input type="checkbox"/>	20. Does anyone in your family have Asthma?	<input type="checkbox"/> <input type="checkbox"/>
3. Has your doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/> <input type="checkbox"/>	21. Have you ever been told that you have a heart murmur?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you ever been hospitalized?	<input type="checkbox"/> <input type="checkbox"/>	22. Does your heart race or skip beats during exercise?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever had surgery?	<input type="checkbox"/> <input type="checkbox"/>	23. Has the doctor ever ordered a test for your heart? (Example: ECG, echocardiogram)	<input type="checkbox"/> <input type="checkbox"/>
6. Are you missing a kidney or other internal organ?	<input type="checkbox"/> <input type="checkbox"/>	24. Does anyone in your family have a heart problem?	<input type="checkbox"/> <input type="checkbox"/>
7. Have you ever had mononucleosis (Mono)?	<input type="checkbox"/> <input type="checkbox"/>	25. Has anyone in your family ever died of heart problems or of a sudden death before age 50?	<input type="checkbox"/> <input type="checkbox"/>
8. Do you have an ongoing medical condition? (diabetes, asthma, seizures, etc)	<input type="checkbox"/> <input type="checkbox"/>	26. Does Marfan's Syndrome run in your family?	<input type="checkbox"/> <input type="checkbox"/>
9. Are you currently taking any medications? (prescription or non-prescription)	<input type="checkbox"/> <input type="checkbox"/>	27. Do you have seizures or epilepsy?	<input type="checkbox"/> <input type="checkbox"/>
10. Do you have any allergies? (medicines, foods, or stinging insects)	<input type="checkbox"/> <input type="checkbox"/>	28. Have you ever had a concussion/head injury?	<input type="checkbox"/> <input type="checkbox"/>
11. Do you have any skin problems? (rashes, itching, severe acne)	<input type="checkbox"/> <input type="checkbox"/>	29. Have you ever been knocked unconscious?	<input type="checkbox"/> <input type="checkbox"/>
12. Do you have any problems with your eyes or vision?	<input type="checkbox"/> <input type="checkbox"/>	30. Have you ever been confused or had memory loss following a head injury?	<input type="checkbox"/> <input type="checkbox"/>
13. Do you take supplements to improve athletic performance?	<input type="checkbox"/> <input type="checkbox"/>	31. Have you ever had heat cramps or heat related illness?	<input type="checkbox"/> <input type="checkbox"/>
14. Have you ever passed out during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	32. Have you ever had a broken bone?	<input type="checkbox"/> <input type="checkbox"/>
15. Have you ever been dizzy during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	33. Have you ever had a stress fracture?	<input type="checkbox"/> <input type="checkbox"/>
16. Have you ever had chest pain during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	34. Have you had a neck/back/ankle/knee/shoulder injury?	<input type="checkbox"/> <input type="checkbox"/>
17. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	35. Have you had any other serious joint injury?	<input type="checkbox"/> <input type="checkbox"/>
18. Have you ever been diagnosed with Asthma?	<input type="checkbox"/> <input type="checkbox"/>		

Explain all YES answers:

Parent or Guardian Acknowledgement:

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

 Printed Name of Parent/Guardian Signature of Parent/Guardian Date

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PHYSICAL EXAM FORM

Part 3: General Examination (to be completed by the examining physician)

	Normal	Abnormal (Describe)		
Eyes, Ears, Nose, Throat:			Pulse:	
Skin:			Blood Pressure:	
Lungs:			Height:	
Heart:			Weight:	
Abdomen:			Visual Acuity:	R: L:
Genitalia/hernia:			Corrected Vision:	Y/N: (circle one)

Part 4: Musculoskeletal Exam (to be completed by the examining physician)

Musculoskeletal Screen	Normal	Abnormal	Describe Abnormal Findings
Neck	ROM		
	Strength		
	Joint Stability		
Shoulder	ROM		
	Strength		
	Joint Stability		
Elbow	ROM		
	Strength		
	Joint Stability		
Forearm/Wrist	ROM		
	Strength		
	Joint Stability		
Hand/Finger	ROM		
	Strength		
	Joint Stability		
Back	ROM		
	Strength		
	Joint Stability		
Hip/Thigh	ROM		
	Strength		
	Joint Stability		
Knee	ROM		
	Strength		
	Joint Stability		
Ankle	ROM		
	Strength		
	Joint Stability		
Foot	ROM		
	Strength		
	Joint Stability		

Part 5: Physician Clearance: (please check the appropriate box)

- Cleared without restrictions Not cleared for athletic participation
 Athletic participation limited to: _____
 Cleared with recommendations for further evaluation/treatment: _____

Stamp of Physician and/or
Physician's Office Below:

Comments

I have examined the above student and found him able to participate in physical activity and the interscholastic athletic program at Moreau Catholic High School.

Doctor's Name: _____ Signed: _____ Date: _____