Date of Exam ___________________________ Date of birth ___________________________

Name ________________________________ Sex ______ Age ______ Grade ______ School ______ Sport(s) ______

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking ______

Do you have any allergies?  □ Yes  □ No  If yes, please identify specific allergy below.  □ Medicines  □ Pollens  □ Food  □ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason?  
   Yes ______  No ______

2. Do you have any ongoing medical conditions? If so, please identify below:  □ Asthma  □ Anemia  □ Diabetes  □ Infections  Other ______

3. Have you ever spent the night in the hospital?  Yes ______  No ______

4. Have you ever had surgery?  Yes ______  No ______

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out during or after exercise?  Yes ______  No ______

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?  Yes ______  No ______

7. Does your heart ever race or skip beats (irregular beats) during exercise?  Yes ______  No ______

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:  □ High blood pressure  □ Heart murmur  □ High cholesterol  □ Heart infection  □ Kawasaki disease  □ Other ______

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)  Yes ______  No ______

10. Do you get lightheaded or feel more short of breath than expected during exercise?  Yes ______  No ______

11. Have you ever had an unexplained seizure?  Yes ______  No ______

12. Do you get more tired or short of breath more quickly than your friends during exercise?  Yes ______  No ______

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?  Yes ______  No ______

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?  Yes ______  No ______

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?  Yes ______  No ______

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  Yes ______  No ______

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?  Yes ______  No ______

18. Have you ever had any broken or fractured bones or dislocated joints?  Yes ______  No ______

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?  Yes ______  No ______

20. Have you ever had a stress fracture?  Yes ______  No ______

21. Have you ever been told that you have or may have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)  Yes ______  No ______

22. Do you regularly use a brace, orthotics, or other assistive device?  Yes ______  No ______

23. Do you have a bone, muscle, or joint injury that bothers you?  Yes ______  No ______

24. Do any of your joints become painful, swollen, feel warm, or look red?  Yes ______  No ______

25. Have you ever had any history of juvenile arthritis or connective tissue disease?  Yes ______  No ______

MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?  Yes ______  No ______

27. Have you ever used an inhaler or taken asthma medicine?  Yes ______  No ______

28. Is there anyone in your family who has asthma?  Yes ______  No ______

29. Were you born without or are you missing a kidney, an eye, a testicle (male), your spleen, or any other organ?  Yes ______  No ______

30. Do you have groin pain or a painful bulge or hernia in the groin area?  Yes ______  No ______

31. Have you had infectious mononucleosis (mono) within the last month?  Yes ______  No ______

32. Do you have any rashes, pressure sores, or other skin problems?  Yes ______  No ______

33. Have you had a herpes or MRSA skin infection?  Yes ______  No ______

34. Have you ever had a head injury or concussion?  Yes ______  No ______

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?  Yes ______  No ______

36. Do you have a history of seizure disorder?  Yes ______  No ______

37. Do you have headaches with exercise?  Yes ______  No ______

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  Yes ______  No ______

39. Have you ever been unable to move your arms or legs after being hit or falling?  Yes ______  No ______

40. Have you ever become ill while exercising in the heat?  Yes ______  No ______

41. Do you get frequent muscle cramps when exercising?  Yes ______  No ______

42. Do you or someone in your family have sickle cell trait or disease?  Yes ______  No ______

43. Have you had any problems with your eyes or vision?  Yes ______  No ______

44. Have you had any eye injuries?  Yes ______  No ______

45. Do you wear glasses or contact lenses?  Yes ______  No ______

46. Do you wear protective eyewear, such as goggles or a face shield?  Yes ______  No ______

47. Do you worry about your weight?  Yes ______  No ______

48. Are you trying to or has anyone recommended that you gain or lose weight?  Yes ______  No ______

49. Are you on a special diet or do you avoid certain types of foods?  Yes ______  No ______

50. Have you ever had an eating disorder?  Yes ______  No ______

51. Do you have any concerns that you would like to discuss with a doctor?  Yes ______  No ______

FEMALES ONLY

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

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

54. How many periods have you had in the last 12 months?  ______

Explain "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 ___________________________ Signature of parent/guardian ___________________________ Date ______

**PREPARTICIPATION PHYSICAL EVALUATION**

**PHYSICAL EXAMINATION FORM**

Name: ____________________________ Date of birth: ________________

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed or anxious?
   - Do you feel safe at your home or residence?

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>Height</th>
<th>Weight</th>
<th>O Male</th>
<th>O Female</th>
<th>BP</th>
<th>Pulse</th>
<th>VisionR 20</th>
<th>L 20</th>
<th>Corrected</th>
<th>O Y</th>
<th>O N</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NORMAL</td>
<td></td>
<td>ABNORMAL FINDINGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precordium</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia (males only)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbows</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrists/Hands/Fingers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/thigh</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg/ankles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Troubles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Consider EKG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
* Consider QP exam if patient being. Having third party present is recommended.
* Consider cognitive evaluation or baseline neuropsychiatric testing for history of significant concussion.

O Cleared for all sports without restriction
O Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________________________

O Not cleared
O Finding further evaluation
O For any sports
O For certain sports ____________________________

Recommendations ____________________________

I have examined the above-named student and completed the preparticipation physical examination. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school/ the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print) ____________________________ Address ____________________________ Phone ____________________________ Date ____________

Signature of physician ____________________________

* MD or DO

[If](2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

HED203 9-2011 10]