**Preparticipation Physical Evaluation**

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam

Name

Sex  Age  Grade  School  Sport(s)

Date of birth

Signature of athlete  Signature of parent/guardian

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

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
<th>Date of birth</th>
<th>Signature of athlete</th>
<th>Signature of parent/guardian</th>
</tr>
</thead>
</table>

Do you have any allergies?  □ Yes  □ No  If yes, please identify specific allergy below.

□ Medicines  □ Pollens  □ Food  □ Stinging Insects

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

<table>
<thead>
<tr>
<th>MEDICAL QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever used an inhaler or taken asthma medicine?</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td>2. Do you have any heart problems? If so, please identify below:  □ Asthma  □ Atherosclerosis  □ Diabetes  □ Infections  □ Other:</td>
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<td>3. Do you have any ongoing medical conditions? If so, please identify below:</td>
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<td>4. Have you ever had a heart attack?</td>
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<td>5. Have you ever had a heart operation?</td>
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<td>6. Have you ever had any unexplained seizures?</td>
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<tr>
<td>7. Have you ever had any unexplained fainting, unexplained syncope, or unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?</td>
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<tr>
<td>8. Have you ever had any unexplained seizures after exercise?</td>
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<tr>
<td>9. Are you taking any medications for your heart condition?</td>
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<tr>
<td>10. Do you have any medical conditions that could affect your heart?</td>
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<tr>
<td>11. Have you ever had any health problems that could affect your heart?</td>
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<td>12. Have you ever had any health problems that could affect your breathing?</td>
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<td>13. Have you ever had any health problems that could affect your circulatory system?</td>
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<td>14. Have you ever had any health problems that could affect your vision?</td>
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<td>15. Have you ever had any health problems that could affect your hearing?</td>
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<td>16. Have you ever had any health problems that could affect your digestive system?</td>
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<td>17. Have you ever had any health problems that could affect your skin?</td>
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<td>18. Have you ever had any health problems that could affect your nervous system?</td>
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<td>19. Have you ever had any health problems that could affect your musculoskeletal system?</td>
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<td>20. Have you ever had any health problems that could affect your endocrine system?</td>
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<td>21. Have you ever had any health problems that could affect your immune system?</td>
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<td>22. Have you ever had any health problems that could affect your reproductive system?</td>
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<td>23. Have you ever had any health problems that could affect your mental health?</td>
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<td>24. Have you ever had any health problems that could affect your social interactions?</td>
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<td>25. Have you ever had any health problems that could affect your school performance?</td>
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<td>26. Have you ever had any health problems that could affect your work performance?</td>
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<td>27. Have you ever had any health problems that could affect your leisure activities?</td>
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<td>28. Have you ever had any health problems that could affect your family relationships?</td>
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<td>29. Have you ever had any health problems that could affect your friends?</td>
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<td>30. Have you ever had any health problems that could affect your pets?</td>
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<td>31. Have you ever had any health problems that could affect your neighbors?</td>
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<td>32. Have you ever had any health problems that could affect your community?</td>
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<td>33. Have you ever had any health problems that could affect your country?</td>
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<td>34. Have you ever had any health problems that could affect your world?</td>
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<tr>
<td>35. Have you ever had any health problems that could affect your universe?</td>
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</table>

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

**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?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

**EXAMINATION**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
<th>BP (mmHg)</th>
<th>Pulse</th>
<th>Vision R 20/20</th>
<th>Vision L 20/20</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

**MEDICAL FINDINGS**

- **Appearance**
  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlexia, myopia, MVP, aortic insufficiency)
- **Lymph nodes**
  - Painless
d- **Heart**
  - Murmurs (auscultation standing, supine, +/− Valsalva)
  - Location of point of maximal impulse (PMI)
- **Pulses**
  - Simultaneous femoral and radial pulses
- **Lungs**
- **Abdomen**
- **Gastrointestinal (males only)**
- **Skin**
  - HSV, lesions suggestive of MRSA, tinea corporis
- **Neurologic**

**MUSCULOSKELETAL**

- **Neck**
- **Back**
- **Shoulder/arm**
- **Elbow/forearm**
- **Wrist/hand/fingers**
- **Hip/thigh**
- **Knee**
- **Leg/ankle**
- **Foot/toes**
- **Functional**
  - Duck-walk, single leg hop

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
*Consider GU exam if in private setting. Having third party present is recommended.
*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

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

☐ Not cleared
  - Pending further evaluation
  - For any sports
  - For certain sports
  - Reason

**Recommendations**

I have examined the above-named student and completed the preparticipation physical evaluation. 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 at 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/type): ____________________________ Date: ____________

Address: ____________________________ Phone: ____________

Signature of physician: ____________________________ MD or DO

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name ___________________________ Sex ☐ M ☐ F Age ______________ Date of birth ______________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ________________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ________________________________

Reason ________________________________

Recommendations ________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. 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 at 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/nurse practitioner (print/type) ___________________________ Date ______________

Address ___________________________ Phone ______________

Signature of physician/nurse practitioner ___________________________ Title ______________

EMERGENCY INFORMATION

Allergies ________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Other information ________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

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