

# Pre-participation Physical Evaluation

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

**In case of emergency, contact:** Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone(H) \_\_\_\_\_ (W) \_\_\_\_\_

**Explain "Yes" answers below.**

**Circle Questions you don't know the answers to.**

- |  |  |           |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |      |  |
|--|--|-----------|-------|-----|------|---------|-------|------|-------|------|-------|------|-----------|----------|--------|-------|-----------|------|--|
| <p>1. Have you had a medical illness or injury since your last check up or sports physical? Y or N</p> <p>2. Have you ever been hospitalized overnight? Y or N</p> <p>3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler? Y or N</p> <p>Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Y or N</p> <p>4. Do you have any allergies (for example: pollen, medicine, food, or stinging insects)? Y or N</p> <p>5. Have you ever passed out during or after exercise? Y or N</p> <p>Have you ever been dizzy during or after exercise? Y or N</p> <p>Have you ever had chest pain during or after exercise? Y or N</p> <p>Do you get tired more quickly than your friends do during exercise? Y or N</p> <p>Have you ever had racing of your heart or skipped heartbeats? Y or N</p> <p>Have you had high blood pressure or high cholesterol? Y or N</p> <p>Have you ever been told you have a heart murmur? Y or N</p> <p>Has any family member of relative died of heart problems or of sudden death before age 50? Y or N</p> <p>Have you had a severe viral infection (for example: myocarditis or mononucleosis within the last month? Y or N</p> <p>Has a physician ever denied or restricted your participation in sports for any heart problems? Y or N</p> <p>6. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)? Y or N</p> <p>7. Have you ever had a head injury or concussion? Y or N</p> <p>Have you ever been knocked out, become unconscious or lost your memory? Y or N</p> <p>Have you ever had a seizure? Y or N</p> <p>Do you have frequent or severe headaches? Y or N</p> <p>Have you ever had numbness or tingling in your arms, hands, legs or feet? Y or N</p> <p>Have you ever had a stinger, burner or pinched nerve? Y or N</p> <p>8. Have you ever become ill from exercising in the heat? Y or N</p> <p>9. Do you cough, wheeze or have trouble breathing during or after activity? Y or N</p> <p>Do you have asthma? Y or N</p> <p>Do you have seasonal allergies that require medical treatment? Y or N</p> | <p>10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? Y or N</p> <p>11. Have you had any problems with your eyes or vision? Y or N</p> <p>Do you wear glasses, contacts or protective eyewear? Y or N</p> <p>12. Have you ever had a sprain, strain or swelling after injury? Y or N</p> <p>Have you broken or fractured any bones or dislocated any joints? Y or N</p> <p>Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Y or N</p> <p><b>If yes, circle appropriate box and explain below</b></p> <table border="0" style="width: 100%;"> <tr> <td>Head</td> <td>Elbow</td> <td>Hip</td> </tr> <tr> <td>Neck</td> <td>Forearm</td> <td>Thigh</td> </tr> <tr> <td>Back</td> <td>Wrist</td> <td>Knee</td> </tr> <tr> <td>Chest</td> <td>Hand</td> <td>Shin/calf</td> </tr> <tr> <td>Shoulder</td> <td>Finger</td> <td>Ankle</td> </tr> <tr> <td>Upper Arm</td> <td>Foot</td> <td></td> </tr> </table> <p>13. Do you want to weigh more or less than you do now? Y or N</p> <p>Do you lose weight regularly to meet weight requirements for your sports? Y or N</p> <p>14. Do you feel stressed out? Y or N</p> | Head      | Elbow | Hip | Neck | Forearm | Thigh | Back | Wrist | Knee | Chest | Hand | Shin/calf | Shoulder | Finger | Ankle | Upper Arm | Foot |  |
| Head   | Elbow  | Hip       |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |      |  |
| Neck   | Forearm  | Thigh     |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |      |  |
| Back   | Wrist  | Knee      |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |      |  |
| Chest  | Hand   | Shin/calf |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |      |  |
| Shoulder   | Finger   | Ankle     |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |      |  |
| Upper Arm  | Foot   |           |       |     |      |         |       |      |       |      |       |      |           |          |        |       |           |      |  |
- FEMALES ONLY**
15. When was your first menstrual period? \_\_\_\_\_
- When was your most recent menstrual period? \_\_\_\_\_
- How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_
- How many periods have you had in the last year? \_\_\_\_\_
- What was the longest time between periods in the last year? \_\_\_\_\_

**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 \_\_\_\_\_ Date \_\_\_\_\_