Preparticipation Physical Evaluation - Physical Form

Last Name			First Name	N	Middle Initial		Date of Birth
Examination							
Height:			Weight:				
BP: / (/)	Pulse:	Vision:	R 20/	L 20/	Corrected Yes No
Medical						Normal	Abnormal Findings
			-arched palate, pectus ex and aortic insufficiency	cavatum, arachnod	actyly, hyperlaxity,		
Eyes / Ears / Nos - Pupils equal / Hea		oat					
Lymph Nodes							
Heart - Murmurs (auscultation	on standin	ıg, ausc	eultation supine, and +/-	Valsalva maneuver			
Lungs							
Abdomen							
Skin - Herpes simplex virus (MRSA), or tinea co		esions	suggestive of methicillin	-resistant Staphyloo	coccus aureus		
Neurologic							
Musculoskeletal:							
- Neck							
- Back							
- Shoulders/Arm							
- Elbow/Forearm							
- Wrist/Hand/Fingers							
- Hip/Thighs							
- Knees							
- Leg/Ankles							
- Foot/Toes	1 .		1.1	1 , 1			
			ngle leg squat test, and b		•		
Medically eligib	ole for al	l sport	P ₁ s without restriction.	reparticipation F	Physical Evaluati	ion	xamination findings or a combination of those. ratment of:
Not medically e	eligible p eligible fo	ending or any	g further evaluation.				
I have examined not have appare conditions arise	the stunt clinial	ident ical c	named on this for contraindications t lete had been clea	m and comple to practice and red for partici	ted the prepar d can participation, the phy	ticipation ph ate in the sp ysician may i	ysical evaluation. The athlete does ort(s) as outlined on this form. If rescind the medical eligibility until athlete and parents or guardians.
Name of health ca	re profe	ession	al (print or type):				Date:
							Phone:
Signature of health							MD, DO, NP, or PA

Preparticipation Physical Evaluation - History Form

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name:	Date of Birth:										
Date of Examination: Sport(s	s):										
List past and current medical conditions:											
Have you ever had surgery? If yes, list all past surgical procedures:											
Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional):											
Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects):											
General Questions. Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No	Medical Questions 16. Do you cough, wheeze, or have difficulty breathing during or	Yes	No						
Do you have any concerns that you would like to discuss with your provider?			after exercise? 17. Are you missing a kidney, an eye, a testicle (males), your spleen,								
Has a provider ever denied or restricted your participation in sports for any reason?			or any other organ? 18. Do you have groin or testicle pain or a painful bulge or hernia in the								
Do you have any ongoing medical issues or recent illness?			groin area?								
Heart Heath Questions About You	Yes	No	19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus								
Have you ever passed out or nearly passed out DURING or AFTER exercise?			aureus (MRSA)? 20. Have you ever had a concussion or head injury that caused								
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			confusion, a prolonged headache, or memory problems?								
Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?			21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling?								
7. Has a doctor ever told you that you have any heart problems?			22. Have you ever become ill while exercising in the heat?								
Has a doctor ever ordered a test for your heart? (for example			23. Do you or someone in your family have sickle cell trait or disease?								
Electrocardiography (ECG) or echocardiography. 9. Do you get lightheaded or feel shorter of breath than your friends			24. Have you ever had or do you have any problems with your eyes or vision?								
during exercise?			25. Do you worry about your weight?								
10. Have you ever had a seizure?			26. Are you trying to or has anyone recommended that you gain or								
Health Questions About Your Family	Yes	No	lose weight?								
11. Has any family member or relative died of heart problems or had			27. Are you on a special Diet or do you avoid certain types of foods?								
an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car accident)?			28. Have you ever had an eating disorder?								
12. Does anyone in your family have a genetic heart problem such as			Females Only	Yes	No						
hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QTsyndrome			29. Have you ever had a menstrual period?								
(LQTS), short QT syndrome (SQTS), Brugada syndrome, or			30. How old were you when you had your first menstrual period?								
catecholaminergic polymorphic ventricular tachycardia (CPVT)?		\vdash	31. When was your most recent menstrual period?								
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?			32. How many periods have you had in the past 12 months?								
Bone and Joint Questions	Yes	No	Explain a "Yes" answer here:								
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a game or practice?											
15. Do you have a bone, muscle, ligament or joint injury that bothers you?											
I hereby state that to the best of my knowledge my	new4	ere ta	o the questions on this form are complete and correct.								
Signature of athlete:											
Signature of parent or guardian:											
Date											

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Parent's Permission& Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print)

As a parent or legal guardian of the above named student-att mission for his/her participation in athletic events and the phy for that participation. I understand that this is simply a screen and not a substitute for regular health care. I also grant perm ment deemed necessary for a condition arising during participevents, including medical or surgical treatment that is recommedical doctor. I grant permission to nurses, trainers and coaphysicians or those under their direction who are part of athlevention and treatment, to have access to necessary medical know that the risk of injury to my child/ward comes with participant during travel to and from play and practice. I have had the understand the risk of injury during participation in sports throwitten information or by some other means. My signature into the best of my knowledge, my answers to the above question and correct. I understand that the data acquired during these may be used for research purposes.	rsical evaluation ing evaluation ission for treat- pation of these mended by a aches as well as etic injury pre- information. I cipation in sports e opportunity to bugh meetings, dicates that to as are complete
Signature of Athlete	Date:
Signature of Parent/Guardian	Date: