

PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name: _____ Birth Date: _____ Exam Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Sport: _____

HISTORY

- | | Y | N | | |
|-----|----|--------------------------|--------------------------|--|
| 1. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week? |
| | e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| | f. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than tonsillectomy? |
| | g. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician? |
| | h. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc)? |
| 2. | | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)? |
| 3. | | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercise? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5. | | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc)? |
| 6. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures or severe dizziness? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or "passed out"? |
| | e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury. |
| 7. | | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. | | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses or protective eye wear? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problem with your eyes or vision? |
| 10. | | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance such as braces, bridge, plate or retainer? |
| 11. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc)? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)? |
| | e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches? |
| | f. | <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. | | <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot? |
| 13. | | <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight? |
| 14. | | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you any menstrual problems? |
| 15. | | <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport? |

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):

PHYSICAL EXAMINATION

Optional

STUDENT NAME: _____

Age: _____

Pulse: _____

Height: _____

Blood Pressure: _____

Weight: _____

Visual Acuity: Left 20/ _____
Right 20/ _____

Urinalysis:

Body Fat %

HCT:

EST VO2 Max:

Audiometry:

Normal

- | | | |
|--------------------------|-----|------------------------------|
| <input type="checkbox"/> | 1. | Head |
| <input type="checkbox"/> | 2. | Eyes (pupils), ENT |
| <input type="checkbox"/> | 3. | Teeth |
| <input type="checkbox"/> | 4. | Chest |
| <input type="checkbox"/> | 5. | Lungs |
| <input type="checkbox"/> | 6. | Heart |
| <input type="checkbox"/> | 7. | Abdomen |
| <input type="checkbox"/> | 8. | Genitalia |
| <input type="checkbox"/> | 9. | Neurologic |
| <input type="checkbox"/> | 10. | Skin |
| <input type="checkbox"/> | 11. | Physical Maturity |
| <input type="checkbox"/> | 12. | Spine, Back |
| <input type="checkbox"/> | 13. | Shoulders, Upper Extremities |
| <input type="checkbox"/> | 14. | Lower Extremities |

Abnormal

- | | |
|--------------------------|-------|
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
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| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |

Assessment: Full Participation
 Limited participation (describe limitations, restrictions):

Participation contraindicated (list reasons):

Recommendations (equipment, taping, rehabilitation, etc.):

DATE: _____ EXAMINER'S SIGNATURE: _____

EXAMINER'S PHONE: () _____ PRINT EXAMINER'S NAME: _____