

PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name: _____ Birth Date: _____ Exam Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Sport: _____

HISTORY

Y N

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

Abnormal

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