

PRE-PARTICIPATION PHYSICAL EVALUATION

Date of Exam: _____

| | | | | |
|---|------------|--------------------|------------|---------------------|
| Name _____ | | Sex _____ | Age _____ | Date of Birth _____ |
| Grade _____ | | Sport(s) _____ | | |
| Address _____ | | Phone _____ | Cell _____ | |
| Personal Physician _____ | | Phone _____ | | |
| Contact in case of emergency: Name _____ | | Relationship _____ | | |
| Phone (H) _____ | Cell _____ | Work _____ | | |

If you don't know the answer to a question, please circle the question. Explain "Yes" answers in area provided.

- | | | | | | | | | | | | | | | | | | | | |
|---|--|-------|-------|-----|------|---------|-------|------|-------|------|-------|------|------|----------|--------|------|-----------|------|-------|
| <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 your gain or lose weight or improve your performance? Y or N</p> <p>4. Do you have any allergies (pollen, medicine, food, stinging bees, etc.)? 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 or relative died of heart problems or of sudden death before age 50? Y or N</p> <p>Have you had a severe viral infection (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 (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 an 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 (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 an 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 style="text-align: center;">If yes, circle problem area and explain below:</p> <table style="width: 100%; border: none;"> <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</td> </tr> <tr> <td>Shoulder</td> <td>Finger</td> <td>Calf</td> </tr> <tr> <td>Upper Arm</td> <td>Foot</td> <td>Ankle</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> <p>FEMALES ONLY</p> <p>15. When was your first menstrual period? _____</p> <p>When was your most recent menstrual period? _____</p> <p>How much time do you usually have from the start of one period to the start of another? _____</p> <p>How many periods have you had in the last year? _____</p> <p>What was the longest time between periods in the last year? _____</p> <p>Explain "Yes" answers here:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | Head | Elbow | Hip | Neck | Forearm | Thigh | Back | Wrist | Knee | Chest | Hand | Shin | Shoulder | Finger | Calf | Upper Arm | Foot | Ankle |
| Head | Elbow | Hip | | | | | | | | | | | | | | | | | |
| Neck | Forearm | Thigh | | | | | | | | | | | | | | | | | |
| Back | Wrist | Knee | | | | | | | | | | | | | | | | | |
| Chest | Hand | Shin | | | | | | | | | | | | | | | | | |
| Shoulder | Finger | Calf | | | | | | | | | | | | | | | | | |
| Upper Arm | Foot | Ankle | | | | | | | | | | | | | | | | | |

| | | |
|--|------------------------|------------|
| I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. | | |
| Athlete Signature _____ | Parent Signature _____ | Date _____ |