Preparticipation Physical Evaluation Form

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam

Name

Age

Sex

Grade

School

Sport(s)

Medications and Allergies: Please list all of the prescription and over-the-counter medications and supplements (medicated and nutritional) that you are currently taking.

[Space for medication list]

Do you have any allergies? [Yes] [No] If yes, please identify specific allergy below.

[Space for allergy list]

Explain “yes” answers below. Circle question you don’t know the answer for.

1. Have you ever had a neck, shoulder or back pain?

2. Do you have any chronic back pain?

3. Have you ever been diagnosed with any chronic pain?

4. Have you ever had surgery?

5. Have you ever had a heart attack or stroke? Yes [No]

6. Have you had any other major surgeries? Yes [No]

7. Have you had any other hospitalization? Yes [No]

8. Have you had any major medical procedures? Yes [No]

9. Have you had any major medical procedures? Yes [No]

10. Have you had any major medical procedures? Yes [No]

11. Have you had any major medical procedures? Yes [No]

12. Have you had any major medical procedures? Yes [No]

13. Have you had any major medical procedures? Yes [No]

14. Have you had any major medical procedures? Yes [No]

15. Have you had any major medical procedures? Yes [No]

16. Have you had any major medical procedures? Yes [No]

17. Have you ever had an injury? Yes [No]

18. Have you ever had an injury? Yes [No]

19. Have you ever had an injury? Yes [No]

20. Have you ever had an injury? Yes [No]

21. Have you ever had an injury? Yes [No]

22. Have you ever had an injury? Yes [No]

23. Have you ever had an injury? Yes [No]

24. Have you ever had an injury? Yes [No]

25. Have you ever had an injury? Yes [No]

26. Have you ever had an injury? Yes [No]

27. Have you ever had an injury? Yes [No]

28. Have you ever had an injury? Yes [No]

29. Have you ever had an injury? Yes [No]

30. Have you ever had an injury? Yes [No]

31. Have you ever had an injury? Yes [No]

32. Have you ever had an injury? Yes [No]

33. Have you ever had an injury? Yes [No]

34. Have you ever had an injury? Yes [No]

35. Have you ever had an injury? Yes [No]

36. Have you ever had an injury? Yes [No]

37. Have you ever had an injury? Yes [No]

38. Have you ever had an injury? Yes [No]

39. Have you ever had an injury? Yes [No]

40. Have you ever had an injury? Yes [No]

41. Have you ever had an injury? Yes [No]

42. Have you ever had an injury? Yes [No]

43. Have you ever had an injury? Yes [No]

44. Have you ever had an injury? Yes [No]

45. Have you ever had an injury? Yes [No]

46. Have you ever had an injury? Yes [No]

47. Have you ever had an injury? Yes [No]

48. Have you ever had an injury? Yes [No]

49. Have you ever had an injury? Yes [No]

50. Have you ever had an injury? Yes [No]

51. Have you ever had an injury? Yes [No]

52. Have you ever had an injury? Yes [No]

53. Have you ever had an injury? Yes [No]

54. Have you ever had an injury? Yes [No]

Explain “yes” answers here.
# Preparticipation Physical Evaluation

**The Athlete with Special Needs: Supplemental History Form**

**Date of Exam:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
</table>

**1. Type of Disability:**

**2. Date of Disability:**

**3. Classification (if available):**

**4. Cause of disability (birth, disease, accident/harm, injury):**

**5. List the sports you are interested in playing:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**6. Do you regularly use a brace, crutches, or prosthesis?**

**7. Do you use any special lenses or an optical device for such?**

**8. Do you have any noises, pressure areas, or any other skin problems?**

**9. Do you have a hearing loss? Do you use a hearing aid?**

**10. Do you have a heart murmur?**

**11. Do you use any special devices for focused or binocular vision?**

**12. Do you have itching or discomfort when wearing glasses?**

**13. Have you had an automobile accident?**

**14. Have you ever been diagnosed with a heart-related (hypertension) or cold-related (hypothermia) illness?**

**15. Do you have muscle or joint pain?**

**16. Do you have frequent urination that cannot be eliminated by medication?**

**Explain "yes" answers here:**

---

**Please indicate if you have ever had any of the following:**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attentional instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for attentional instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints more than once</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bruised gums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroesophageal or esophageal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anorexia or eating in excess</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or weakness in arm or leg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arm or hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
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<tr>
<td>Recent change to medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lobotomy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explain "yes" answers here:**

---

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and accurate.

**Signature of athlete:**

**Signature of parent/guardian:**

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# Preparticipation Physical Examination

## PHYSICAL EXAMINATION FORM

### PHYSICIAN REMINDERS

1. Complete additional questions on the following topics:
   - Do you have any bleeding disorders?
   - Do you have a history of asthma or allergies?
   - Do you have any medications or supplements?
   - Do you have a history of any cardiovascular problems?
   - Do you have any history of diabetes, hypertension, or obesity?
   - Are you a current smoker or do you smoke any tobacco products?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Are you reared in a warm, dry climate, and are you considering?

2. Complete these questions on cardiovascular symptoms questions 5-19.

### EXAMINATION

<table>
<thead>
<tr>
<th>Height (cm)</th>
<th>Weight (kg)</th>
<th>M</th>
<th>F</th>
<th>males</th>
<th>females</th>
<th>Home</th>
<th>School</th>
<th>Family</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### MEDICAL

| Appearance | Cardiac | Pulmonary | Integumentary | Musculoskeletal | Neurological | Endocrine | Gastrointestinal | Genitourinary | Orthopedic | Skin | Vision | Hearing | Speech | Immune | Nails | Hair | Other |
|------------|--------|-----------|---------------|----------------|--------------|-----------|------------------|---------------|------------|------|--------|---------|--------|--------|-------|-------|-------|-------|
|             |        |           |               |                |              |           |                  |               |            |      |        |         |        |        |       |       |       |       |

### ADDITIONAL FINDINGS

- Circumference:  
- Blood Pressure:  
- Temperature:  
- Respiration: 
- Heart Rate:  
- Blood Glucose:  
- Urine 
- Stool 
- Breathing:  
- Voice:  
- Speech:  
- Hearing:  
- Vision:  
- Hair:  
- Nails:  
- Skin:  

### Recommendations

I have examined the above-named student and completed the preparticipation physical examination. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. The physical examination is repeated annually by my office and can be made available to the school on request by the parents. It is recommended that the athlete be re-examined for participation, a physician may assign the clearance until the problem is resolved and the potential consequences are completely examined to the athlete (and parent/guardian).

Name of physician:  
Address:  
Signature of physician:  
Date:  
Place:  

[Signature of physician] 

[Date] 

[Place]

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[2010/12/20]