



Preparticipation Physical Evaluation

Name _____ Sex: _____ Age _____ Birthday: _____
 Grade _____ School _____ Sport(s) _____
 Address _____ Phone _____
In case of emergency, contact:
 Name _____ Relationship _____ Phone _____

Explain "Yes" Answers below. Circle questions you do not know the answers to.		Y	N			Y	N																
1	Has a doctor ever denied or restricted your participation in sports for any reason?			26	Have you ever used an inhaler or taken asthma medicine?																		
2	Do you have an ongoing medical condition (like diabetes or asthma)?			27	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?																		
3	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?			28	Have you had infectious mononucleosis (mono) within the last month?																		
4	Do you have allergies to medicines, pollens, foods, or stinging insects?			29	Do you have any rashes, pressure sores, or other skin problems?																		
5	Have you ever passed out or nearly passed out DURING exercise?			30	Have you had a herpes skin infection?																		
6	Have you ever passed out or nearly passes out AFTER exercise?			31	Have you ever has a head injury or concussion?																		
7	Have you ever had discomfort, pain, or pressure in your chest during exercise?			32	Have you been hit in the head and been confused or lost your memory?																		
8	Does your heart race or skip beats during exercise?			33	Have you ever has a seizure?																		
9	Has a doctor ever told you that you have: (Circle all that apply) *High Blood Pressure *High Cholesterol *A Heart Murmur *A Heart Infection			34	Do you have headaches with exercise?																		
10	Has a doctor ever ordered a test for your heart (for example ECG)?			35	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?																		
11	Has anyone in your family died for no apparent reason?			36	Have you ever been unable to move your arms or legs after being hit or falling?																		
12	Does anyone in your family have a heart problem?			37	When exercising in the heat, do you have severe muscle cramps or become ill?																		
13	Has any family member or relative died of heart problems or of sudden death before age 50?			38	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?																		
14	Does anyone in your family have Marfan syndrome?			39	Have you had any problems with your eyes or vision?																		
15	Have you ever spent the night in a hospital?			40	Do you wear glasses or contact lenses?																		
16	Have you ever had surgery?			41	Do you wear protective eyewear, such as goggles or a face shield?																		
17	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendinitis that caused you to miss a practice or game? If yes, circle below:			42	Are you happy with your weight?																		
18	Have you had any problem or fractured bones or dislocated joints? If yes, circle below:			43	Are you trying to lose or gain weight?																		
19	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:			44	Has anyone recommended you change your weight or eating habits?																		
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper Arm</td> <td>Elbow</td> <td>Forearm</td> <td>Hand/Fingers</td> <td>Chest</td> </tr> <tr> <td>Upper Back</td> <td>Lower Back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/Shin</td> <td>Ankle</td> <td>Foot/Toes</td> </tr> </table>				Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest	Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes	45	Do you limit or carefully control what you eat?		
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest																
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes																
20	Have you ever had a stress fracture?			46	Do you have any concerns that you would like to discuss with a doctor?																		
21	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?			Females Only:																			
22	Do you regularly use a brace or assistive device?			47	Have you ever had a menstrual period?																		
23	Has a doctor ever told you that you have asthma or allergies?			48	How old were you when you had your first menstrual period?																		
24	Do you cough, wheeze, or have difficulty breathing during or after exercise?			49	How many periods have you had in the last 12 months?																		
25	Is there anyone in your family who has asthma?			Explain "Yes" answers here: _____ _____ _____ _____ _____																			

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
 Signature of athlete: _____ Signature of parent/guardian: _____ Date: _____