Pre-Participation History and Physical Examination

Name_____ Birth Date_____ Exam Date_____

Address_____City_____Zip_____

Phone_____ Grade_____

History

Yes No

__ __ Have you had any illness/injury recently, or do you have an illness/injury now?
__ __ Have you had a medical problem, illness or injury since your last exam?
__ __ Do you have any chronic or recurrent illness?
__ __ Have you ever had any illness lasting more than a week?
__ __ Have you ever been hospitalized overnight?
__ __ Have you had any surgery?
__ __ Have you ever had any injuries requiring treatment by a physician?
__ __ Are you presently taking ANY medications (including vitamins, aspirin, etc)?
__ __ Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
__ __ Do you tire more easily or quickly than your friends during exercise?
__ __ Have you ever had any problem with your blood pressure or your heart?
__ __ Have any close relatives had heart problems, heart attack, or sudden death before they were age 50?
__ __ Do you have any skin problems (acne, itching, rashes, etc) ?
__ __ Have you ever had fainting, convulsions, seizures or severe dizziness?
__ __ Do you have frequent severe headaches?
__ __ Have you ever had a 'stinger' or 'burner' or 'pinched nerve'?
__ __ Have you ever been 'knocked out' or 'passed out'?
__ __ Have you ever had a neck or head injury?
__ __ Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
__ __ Have you had asthma, or trouble breathing, or cough during or after exercise?
__ __ Do you wear eyeglasses, contact lenses, or protective eye wear?
__ __ Have you had any problem with your eyes or vision?
__ __ Do you wear any dental appliance such as braces, bridge, plate, retainer?
__ __ Have you ever had a knee injury?
__ __ Have you ever had an ankle injury?
__ __ Have you ever injured any other joint (shoulder, wrist, fingers, etc)?
__ __ Have you ever had a broken bone (fracture)?
__ __ Have you ever had a cast, splint, or had to use crutches?
__ __ Must you use special equipment for competition (pads, braces, neck roll, etc)?
__ __ Has it been more than 5 years since your last tetanus booster shot?
__ __ Are you worried about your weight?
__ __ FEMALES: Do you have any menstrual problems?
__ __ Have you any medical concerns about participating in sports?

Patient should not write below this line

Examiner's comments on all 'Yes' answers:

_____

Physical Examination

Age_____ Pulse_____ Height_____Blood Pressure_____ Weight_____ Visual acuity Left 20/_____ Right 20/_____	**Optional** Urinalysis: Body Fat%: HCT: EST VO2 Max: Audiometry::

Normal

___ Head_____

___ Eyes (pupils), ENT_____

___ Teeth_____

___ Chest_____

___ Lungs_____

___ Heart_____

___ Abdomen_____

___ Neurologic_____

___ Skin_____

___ Physical Maturity_____

___ Spine, Back_____

___ Shoulders, Extremities_____

___ Genetalia_____

Immunizations:_____

Recommendations:_____

Date:_____ Examiner's Signature_____

Examiner's Phone_____ Print Examiner's Name_____