Pre-participation Examination

To be completed by athlete or parent

Name____ Sport/Position_______________

Last First Middle

Social Security Number ______________________________ School Year __________________

College Address ____

City/State ____ Phone No. __________________

Date of Birth______________________ Age ______ Cell Phone No. ___________________

Parent's Name ____

Home Address ____

Phone No. _________________________________

Person to contact in case of emergency ____

Phone No. _________________________________

Family Doctor ______________________________ City/State __________________________

Phone No. _________________________________

PAST MEDICAL HISTORY

	Question	Yes	No	If yes, please explain (what, where, when)
1.	Presently taking medication (including birth control pills)?	☐	☐	_______________
2.	Have you been diagnosed with asthma?	☐	☐	_______________
3.	Have you been prescribed by a physician to use an asthma medication?	☐	☐	_______________
4.	Allergic to medicine, food, bee stings?	☐	☐	_______________
5.	Wears any appliances – glasses, contact lenses?	☐	☐	_______________
6.	History of braces, chipped teeth, bridges?	☐	☐	_______________
7.	Has ongoing medical problem?	☐	☐	_______________
8.	Had serious or significant illness in past?	☐	☐	_______________
9.	Any past surgical operations, accidents, non-sports or related injuries?	☐	☐	_______________
10.	Any past injuries directly related to sports?	☐	☐	_______________
11.	Any hospitalization not explained above?	☐	☐	_______________
12.	Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?	☐	☐	_______________
13.	Any serious family illness (such as diabetes, bleeding disorders, etc.)?	☐	☐	_______________
14.	***Heart***			
	Have you ever passed out during or after exercise?	☐	☐	_______________
	Have you ever been dizzy during or after exercise?	☐	☐	_______________
	Have you ever had chest pain during or after exercise?	☐	☐	_______________
	Do you get tired more quickly than your friends do during exercise?	☐	☐	_______________
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐	_______________
	Have you had high blood pressure or high cholesterol?	☐	☐	_______________
	Have you ever been told you have a heart murmur?	☐	☐	_______________
	Has any family member or relative died or heart problems or of sudden death before age 50?	☐	☐	_______________
	Have you had a severe viral infection (for example myocarditis or mononucleosis) within the past month?	☐	☐	_______________
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐	_______________
	Has anyone in your family had a heart attack before the age of 50?	☐	☐	_______________
15.	***Head and Nerve***			
	Have you ever had a head injury or concussion?	☐	☐	_______________
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐	_______________
	Have you ever had a seizure?	☐	☐	_______________
	Do you have frequent or severe headaches?	☐	☐	_______________
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐	_______________
	Have you ever had a stinger, burner or pinched nerve?	☐	☐	_______________

16. Last tetanus shot Date ___________________

17. Last eye exam Date ___________________

18. Last menstrual period (If women) Date ___________________

PERSONAL HABITS

		Yes	***No***
1.	Smoking/smokeless tobacco	☐	☐
2.	Alcohol/non-medical drugs: marijuana, cocaine, etc	☐	☐
3.	Steroids	☐	☐
4.	Eating Disorders – weight loss or gain?	☐	☐

Review of systems (Please check if you have any problems with any of the following areas of your body)

☐ Skin	☐ Head	☐ Shoulders, Arms
☐ Fatigue	☐ Heart	☐ Mouth/Throat
☐ Neck	☐ Eyes	☐ Hips, Legs, Feet
☐ Hands	☐ Ears	☐ Mental, Emotional
☐ Back	☐ Nose	☐ Muscles-Strength, Feeling
☐ Lungs	☐ Abdomen	☐ Nutrition, Weight Control

☐ Genital (including menstrual for women ☐ Other: What? ___________________

I certify that the above information is correct to the best of my knowledge.

Student Signature ____

PHYSCIAL EXAMINATION

Height _________________ Weight ___________________ Blood Pressure _______________

Pulse: resting _____________ 1 min. exercise_______________ after 1 min. rest___________

Pulse Ox: Resting___________ 1 min. exercise ______________ after 1 min. rest ___________

Visual Acuity: Eyes (R) 20/ ___________ (L) 20/___________ Corrected: ____Y ____N

Finger-tip span: __________________________________ BMI:_________________________

Other Testing	***Normal***	***Abnormal Findings***
1. General	☐	______________________
2. Skin	☐	______________________
3. HEENT	☐	______________________
4. Teeth (Dental Exam)	☐	______________________
5. Neck	☐	______________________
6. Lungs	☐	______________________
7. Heart (Sit and Stand)	☐	______________________
8. Abdomen	☐	______________________
9. Genitalia	☐	______________________
10. Musculoskeletal		
Neck	☐	______________________
Shoulder/Arm	☐	______________________
Elbow/Forearm	☐	______________________
Wrist/Hand	☐	______________________
Back	☐	______________________
Hip/Thigh	☐	______________________
Knee	☐	______________________
Shin/Calf	☐	______________________
Ankle/Leg	☐	______________________
Foot	☐	______________________
11. Peripheral Pulses	☐	______________________
12. Neurologic	☐	______________________
13. Mental Status	☐	______________________
14. Marfan Screen	☐	______________________

Other Tests (optional)

☐ Auditory ☐ UA ☐ EKG ☐ Hgb/Hct ☐ Tanner Stage
☐ % Body Fat ☐ Drug Screen ☐ Chest X-Ray ☐ SMAC

On the basis of the examination on this day, I approve this student's participation in interscholastic sports for one year. ☐ Yes ☐ No ☐ Limited

Additional Comments:

____ _____________________
Physician/APN/PA Signature Date

____ _____________________
Trainer's Signature Date

____
Student's Name

Athletic Physical