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.

1. Have you had a medical illness or injury since your last check up or sports physical? Y or N
2. Have you ever been hospitalized overnight? Y or N
3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler? Y or N
   Have you ever taken any supplements or vitamins to help your gain or lose weight or improve your performance? Y or N
4. Do you have any allergies (pollen, medicine, food, stinging bees, etc.)? Y or N
5. Have you ever passed out during or after exercise? Y or N
   Have you ever been dizzy during or after exercise? Y or N
   Have you ever had chest pain during or after exercise? Y or N
   Do you get tired more quickly than your friends do during exercise? Y or N
   Have you ever had racing of your heart or skipped heartbeats? Y or N
   Have you had high blood pressure or high cholesterol? Y or N
   Have you ever been told you have a heart murmur? Y or N
   Has any family member or relative died of heart problems or of sudden death before age 50? Y or N
   Have you had a severe viral infection (example: myocarditis or mononucleosis within the last month? Y or N
   Has a physician ever denied or restricted your participation in sports for any heart problems? Y or N
6. Do you have any current skin problems (itching, rashes, acne, warts, fungus or blisters)? Y or N
7. Have you ever had a head injury or concussion? Y or N
   Have you ever been knocked out, become unconscious or lost your memory? Y or N
   Have you ever had a seizure? Y or N
   Do you have frequent or severe headaches? Y or N
   Have you ever had numbness or tingling in your arms, hands, legs or feet? Y or N
   Have you ever had a stinger, burner or pinched nerve? Y or N
8. Have you ever become ill from exercising in the heat? Y or N
9. Do you cough, wheeze or have trouble breathing during or after an activity? Y or N
   Do you have asthma? Y or N
   Do you have seasonal allergies that require medical treatment? Y or N
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
11. Have you had any problems with your eyes or vision? Y or N
    Do you wear glasses, contacts or protective eyewear? Y or N
12. Have you ever had a sprain, strain or swelling after an injury? Y or N
    Have you broken or fractured any bones or dislocated any joints? Y or N
    Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Y or N

    If yes, circle problem area and explain below:

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin
Shoulder	Finger	Calf
Upper Arm	Foot	Ankle

13. Do you want to weight more or less than you do now? Y or N
    Do you lose weight regularly to meet weight requirements for your sports? Y or N
14. Do you feel stressed out? Y or N

FEMALES ONLY

15. When was your first menstrual period? _____
    When was your most recent menstrual period? _____
    How much time do you usually have from the start of one period to the start of another? _____
    How many periods have you had in the last year? _____
    What was the longest time between periods in the last year? _____

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

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_____