Physical Examination Form

Last Name	First Name	Middle Initial	Date of Birth

Examination			
Height:	Weight:	___ Male ___ Female	BP /
Pulse	Vision: R 20/	L 20/	Corrected ___ Yes ___ No

Medical	Normal	Abnormal Findings
Appearance: Marfan syndrome (kyphoscoliosis, high –arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes / Ears / Nose / Throat - Pupils equal / Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva • Location of point of maximum impulse (PMI)		
Pulses - Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin - HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
Musculoskeletal:		
• Neck		
• Spine/Back		
• Shoulders/Arm		
• Elbow/Forearm		
• Wrist/Hand/Fingers		
• Hip/Thighs		
• Knees		
• Leg/Ankles		
• Foot/Toes		
• Functional: Duck-walk, single leg hop		

Consider: ECG, echocardiogram and referral to cardiology for abnormal cardiac history or event. Consider GU Exam if in a private setting. Having a third party present is recommended. Consider cognitive evaluation or baseline neuropsychiatric testing if a history or significant concussion.

____ **Cleared for all sports without restriction**

____ **Cleared for all sports without restriction with recommendations for further evaluation or treatment for:**_____

_____

____ **Not Cleared:** (check all that apply) ___ Pending further evaluation ___ For Any Sports ____ For Certain Sports: _____

Reason: _____

Recommendation: _____

I have examined the above-named student and completed the participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete had been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and parents.

Physician's Signature: _____ Date: _____

Physician's Address: _____ Phone _____

Physician's Reminders: Consider additional questions on more sensitive issues: (at risk behavior, alcohol, drugs, supplements...)

Pre-Participation Physical Evaluation Medical History Questionnaire

Note: This form is to be filled out by the parent(s) and student prior to seeing the physician.

Student's Name _____ Date of Birth _____ Exam Date _____

Sex _____ Age _____ Grade _____ School _____ Sports _____

Medicine and Allergies: List all prescriptions and over the counter and supplements (herbal & nutritional) that you are taking: _____

Do you have an allergy? ___ Yes ___ No If yes, please specify: ___ Medicine ___ Pollens ___ Food ___ Stinging insects ___ Other _____

General Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions, If so Identify: ___Asthma ___Anemia ___Diabetes ___Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
Heart Heath Questions About You	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had pain, discomfort, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ___High Blood Pressure ___A heart murmur ___High cholesterol ___A heart infection ___Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (for example ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
Health Questions About Your Family	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (*including drowning, unexplained car accident, sudden death syndrome*)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QTsyndrome, short QT syndrome, Brugada syndrome, or catecholaminergic, polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
Bone and Joint Questions	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a game or practice?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

Medical Questions	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) in the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying or has anyone recommended that you gain or lose weight?		
49. Are you on a special Diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
Females Only	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the past 12 months?		

Explain any "YES" answers here or on an additional page and attach to this questionnaire.

_____

_____

_____

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

Athlete's Signature _____

Parent/Guardian Signature _____

Date _____

Explain "Yes" answers below. Circle question if you do not know the answer.