

PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

This form is not required as long as the conditions of 18.13.0 are met.

NAME: _____ Birth Date: _____ Exam Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Cell: _____ SPORT: _____

HISTORY

- | | YES | NO | |
|-------|--------------------------|--------------------------|--|
| 1 a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week? |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than tonsillectomy? |
| g. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician? |
| h. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4 a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercise? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc.)? |
| 6 a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures or severe dizziness? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or "passed out"? |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9 a. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses or protective eye wear? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problem with your eyes or vision? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance such as braces, bridge, plate, retainer? |
| 11 a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)? |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches? |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot? |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight? |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you any menstrual problems? |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport? |

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):

PHYSICAL EXAMINATION

NAME: _____ SPORT _____ Exam Date: _____

Age: _____ Pulse: _____

Height: _____ Blood Pressure: _____

Weight: _____ Visual Acuity: Left 20/ _____
Right 20/ _____

Optional

Urinalysis:
Body Fat %
HCT:
EST VO2 Max:
Audiometry:

Normal

Abnormal

<input type="checkbox"/>	1.	Head	<input type="checkbox"/>	_____
<input type="checkbox"/>	2.	Eyes (pupils), ENT	<input type="checkbox"/>	_____
<input type="checkbox"/>	3.	Teeth	<input type="checkbox"/>	_____
<input type="checkbox"/>	4.	Chest	<input type="checkbox"/>	_____
<input type="checkbox"/>	5.	Lungs	<input type="checkbox"/>	_____
<input type="checkbox"/>	6.	Heart	<input type="checkbox"/>	_____
<input type="checkbox"/>	7.	Abdomen	<input type="checkbox"/>	_____
<input type="checkbox"/>	8.	Genitalia	<input type="checkbox"/>	_____
<input type="checkbox"/>	9.	Neurologic	<input type="checkbox"/>	_____
<input type="checkbox"/>	10.	Skin	<input type="checkbox"/>	_____
<input type="checkbox"/>	11.	Physical Maturity	<input type="checkbox"/>	_____
<input type="checkbox"/>	12.	Spine, Back	<input type="checkbox"/>	_____
<input type="checkbox"/>	13.	Shoulders, Upper extremities	<input type="checkbox"/>	_____
<input type="checkbox"/>	14.	Lower extremities	<input type="checkbox"/>	_____

Assessment: Full participation
 Limited participation (describe limitations, restrictions):

Participation contraindicated (list reasons):

Recommendations (equipment, taping, rehabilitation, etc.):

DATE: _____

EXAMINER'S SIGNATURE: _____

EXAMINER'S PHONE: () _____

PRINT EXAMINER'S NAME: _____

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