

Preparticipation Physical Evaluation

History Form

Name _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Personal Physician _____ Provincial Health Care # _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ Phone (W) _____

Explain "Yes" answers below.

Circle questions you don't know the answers to.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since you last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have an ongoing medical condition (diabetes)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you currently taking any prescription or non-prescription (over-the-counter-) medication or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had discomfort, pain, or pressure in you chest during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Does you heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a doctor ever told you that you have (Circle all that apply) | | |
| High blood pressure | | |
| A heart murmur | | |
| High cholesterol | | |
| A heart infection | | |
| 12. Has a doctor ordered a test for your heart | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden unexpected death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| How many times? _____ When was the last concussion? _____ | | |
| How severe was each one? (Explain below) | | |
| 19. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had a burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Have you ever gotten unexpectedly short of breath during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 26. Do you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Do you wear protective eyewear (goggles or a face shield)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you had any broken or fractured bones or dislocated joints? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast, or crutches? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> |
| Head | Elbow | Hip |
| Neck | Forearm | Thigh |
| Back | Wrist | Knee |
| Chest | Hand | Shin/Calf |
| Shoulder | Finger | Ankle |
| Upper Arm | | Foot |
| 37. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Are you stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| Record dates of your most recent immunizations (shots) for: | | |
| Tetanus _____ Measles _____ | | |
| Hepatitis B _____ Chickenpox _____ | | |

Explain "Yes" answers here:

*It is understood that even though the athlete, whenever needed wears protective equipment, the possibility of an injury still remains. Due to the nature of sport and physical activity, I understand the risks involved include a full range of injuries including permanent injury or death. I knowingly assume responsibility for any and all such risks and all such injuries. Thereof, I do hereby voluntarily choose to participate in this sport and accept the risks as a condition of my participation.

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

Signature of Athlete _____ Signature of Parent/Guardian _____ Date _____

Preparticipation Physical Evaluation

Physical Examination Form

Name _____ Date of Birth _____
 Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____ (_____ / _____)
 Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils Equal _____ Unequal _____

	Normal	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Notes: _____

Name of physician (print) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____

**2004 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Preparticipation Physical Evaluation

Clearance Form

Name _____ Sex _____ Age _____ Date of Birth _____

Cleared without restriction

Cleared, with recommendations for further evaluation or treatment for: _____

Not Cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

Name of physician (print) _____ Date _____

Address _____ Phone _____

Signature of physician _____

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