PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name: _____ Birth Date: _____Today's Date: _____

Address: _____ City: _____ Zip:_____

Phone: _____ Sport: _____

HISTORY

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

For all "yes" answers above, please explain on the lines below

PARENT / PATIENT COMMENTS ON ALL "YES" ANSWERS (refer to question number):

_____

_____

_____

_____

_____

_____ _____

(Signature) (Relationship to Patient)

PHYSICAL EXAMINATION

Age:_____ Pulse:_____

Height:_____ Blood Pressure:_____

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

Optional

Urinalysis:

Body Fat %

HCT:

EST VO2 Max:

Audiometry:

Normal			Abnormal	
☐	1.	Head	☐	
☐	2.	Eyes (pupils), ENT	☐	
☐	3.	Teeth	☐	
☐	4.	Chest	☐	
☐	5.	Lungs	☐	
☐	6.	Heart	☐	
☐	7.	Abdomen	☐	
☐	8.	Genitalia	☐	
☐	9.	Neurologic	☐	
☐	10.	Skin	☐	
☐	11.	Physical Maturity	☐	
☐	12.	Spine, Back	☐	
☐	13.	Shoulders, Upper extremities	☐	
☐	14.	Lower extremities	☐	

Assessment: ☐ Full participation

☐ Limited participation (describe limitations, restrictions):

_____

_____

☐ Participation contraindicated (list reasons):

_____

_____

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

_____

_____

EXAMINER'S SIGNATURE: _____PRINT EXAMINER'S NAME: _____

DATE OF EXAM_____ EXAMINER'S PHONE: (509)575-0114

HISTORY REVIEWED BY:_____PRINT REVIEWER'S NAME:_____

(SIGNATURE)

DATE HISTORY REVIEWED:_____(NOTE: NO EXAM WAS DONE AT THIS TIME)