# Preparticipation Sports Examination

## *Medical History*

Please answer the following questions by circling yes or no. If you answer yes, please explain at the bottom of the form and on back if necessary.

1. Have you ever had a serious medical problem requiring surgery, hospitalization or prolonged treatment by a doctor? Yes No
2. Do you take any medication of any type? Yes No
3. Have you ever had a severe allergic reaction to anything? Yes No
4. Have you ever had allergic problems such as hay fever, asthma or eczema? Yes No
5. Do you have difficult breathing or wheezing during or shortly after exercising? Yes No
6. Have you ever had a heart murmur, racing heart or irregular heart beat? Yes No
7. Have you ever been dizzy or passed out during exercise?* Yes No
8. Has any family member ever had a heart attack or died suddenly before age 50? Yes No
9. Do you have chest pain or tire more easily than others your age when exercising? Yes No
10. Have you ever suffered heat related problems such as heat cramps, severe headache, dizziness or passing out? Yes No
11. Have you ever had a significant injury such as a sprain, fracture or dislocation to a bone or joint or persistent back/neck pain? Yes No
12. Have you ever had a concussion or been knocked unconscious? Yes No
13. Have you ever had a seizure? Yes No
14. Have you ever had burning pain, numbness or tingling in your arms or legs associated with any athletic or physical activity? Yes No
15. Is there any other medical or family history which might be important? Yes No
16. Have you ever been taken out of or kept from participating in a sports activity or practice for an injury or physical reason? Yes No
17. Have you ever required taping, padding or bracing before events or practice? Yes No
18. Do you have damage or absence of one of any paired organs (i.e., kidney, testicle, eye, etc.)? Yes No
19. Do you have any skin problems (rash, itching)? Yes No
20. In the last year, how much weight have you gained or lost? ____________
21. What is the date of your last tetanus booster? ____________
22. What is the date of your last MMR? ____________
23. Do you or any members of your family have a history of sickle cell trait? Yes No Uncertain

**For Females Only:**

24. What is the date of your last menstrual period? ____________
25. In the last year have you gone for three months or more without a menstrual cycle? Yes No

## *Physical*

height__________ blood pressure__________ *>140/85?__________
weight__________ pulse__________
vision R corrected__________ uncorrected__________
L corrected__________ uncorrected__________
glasses__________ contact lenses R_____ L_____ both_____
general observations: ____________
Tanner maturity staging: ____________
HEENT: ____________
Neck: ROM__________ palpation__________ tenderness__________
Chest: auscultation____________
wheezing?__________ Rales?__________
CV: heart murmur____________
* murmur increase with valsalva?__________
* murmur grade III or IV?__________
* murmur diastolic?__________

rhythm__________ click__________ rub__________
pulses: carotid__________ radial__________ pedal (DP_____ PT_____)
edema?__________ cyanosis?__________
Abdomen____________
* enlarged liver?__________ * enlarged spleen?__________
hernia?__________ scars?__________
GU: male__________ testicles R__________ L__________
female____________
inguinal hernia?____________
Skin: gen.____________
rashes__________ impetigo__________ herpes s.__________
**MS shoulder____________
elbow____________
wrist/hand____________
back____________
hip____________
knee____________
ankle____________
feet____________
other____________

identified problems: 1____________
2____________
3____________
recommendations coach/athletic trainer:____________

* Marfan? >2 (tall _____ striae _____ hyperextensibility __________
upper to lower body ratio <0.9 _____ lens dislocation __________)

* requires additional evaluation
** detailed exam if history of injury or problem

**The above named individual has been cleared for participation in the following sports:**

_____ Contact collision (football, soccer, wrestling, etc.)
_____ Limited contact impact (baseball, basketball, volleyball)
_____ Noncontact strenuous (track, field, running, tennis, etc.)
_____ Noncontact moderately strenuous (badminton, table tennis)
_____ Noncontact nonstrenuous (golf, archery, riflery)

**Additional evaluation suggested:**

_____ none
_____ coach/athletic trainer notification and clearance
_____ physician
family physician __________
sports physician __________
orthopedic surgeon __________
other __________

Provider's/Physician's signature ____________

Physician's Name ____________ Date__________
(Physician's name [printed] must also appear if examination is given by an Advanced Nurse Practitioner or a Certified Physician's Assistant in written collaborative practice with a physician)

(continued on reverse side)