Wheatland Memorial Healthcare

Bair Memorial Clinic

PRE-PARTICIPATION PHYSICAL EVALUATION for INTERSCHOLASTIC ATHLETICS

This page to be completed by physician/nurse practitioner/physician assistant

NAME:_____ Date of Birth:_____

HEIGHT:_____ WEIGHT:_____ % BODY FAT (optional)_____ PULSE:_____ BP:_____

VISION: R 20/____L 20/_____ CORRECTED? Y__ N___PUPILS: EQUAL_____ UNEQUAL_____

	NORMAL	ABNORMAL FINDING	INITIALS *
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE:

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:_____

_____

_____

☐ NOT cleared for [Sport(s)]:_____ Reason:_____

Recommendation:_____

Name of Physician/Nurse Practitioner/Physician's Assistant _____Date:_____

Print or Type

Address:_____Phone:_____

Signature of Physician/Nurse Practitioner/Physician Assistant_____

Date of Exam:_____

PHYSICIANS STAMP:

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the provider. The provider should keep this form in the chart.)

NAME:_____ **Date of Birth**_____

Sex_____ **Age**_____ **Grade**_____ **School**_____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal/nutritional) that you are currently taking.

Do you have any allergies? Yes_____ No_____ If yes, please identify specific allergy below.
_____Medicines _____ Pollen _____Food _____Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

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 medicals conditions? If so, please identify ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	YES	NO
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, 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?		
HEART HEALTH QUESTIONS ABOUT OUR FAMILY	YES	NO
13. Has any family memer or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	YES	NO
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
17. Have you ever had any broken or fractured or dislocated joints?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever had a stress fracture?		
20. Do you regularly use a brace, orthotics, or other assistive device?		
21. Do you have a bone, muscle, or joint injury that bothers you?		
22. Do any of your joints become painful, swollen, feel warm, or look red?		

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

Explain "yes" answers here:

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

X Signature of Athlete_____ Signature of Parent/Guardian_____ Date:_____