

# PRE-PARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM



Name:	Date of Birth:
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**Physician Reminders:**

1. Consider additional questions on more sensitive issues.
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplements?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Questions 5-14).

**EXAMINATION**

Height:	Weight:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
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BP: / ( / )	Pulse:	Vision: R 20/ L 20/	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
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Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
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Eyes/Ears/Nose/Throat • Pupils equal • Hearing		
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Lymph Nodes		
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Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal pulse (PMI)		
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Pulses • Simultaneous femoral and radial pulses		
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Lungs		
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Abdomen		
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Genitourinary (males only)**		
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Skin • HSV, lesions suggestive of MRSA, tinea corporis		
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Neurologic***		
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<b>MUSCULOSKELETAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
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Neck		
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Back		
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Shoulder/arm		
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Elbow/forearm		
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Hip/thigh		
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Knee		
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Leg/ankle		
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Foot/toes		
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Functional • Duck-walk, single leg hop		
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\* Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam; \*\*Consider GU exam if in private setting. Having third party present is recommended.

\*\*\*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

<input type="checkbox"/> Cleared for all sports without restriction.		
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<input type="checkbox"/> Cleared for all sports without restriction <b>with recommendations for further evaluation or treatment for:</b>		
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<input type="checkbox"/> Not Cleared <input type="checkbox"/> Pending further evaluation <input type="checkbox"/> For any sports <input type="checkbox"/> For certain sports (please list): Reason:		
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Recommendations:		
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**I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of Physician (type/print):	Date:
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Address:	Phone:
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Signature of Physician (MD/DO/ARNP/PA/Chiropractor):	
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