

# Preparticipation Physical Evaluation

## History

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sport: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Person to contact in case of emergency, preferably parents:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_ Work Phone: \_\_\_\_\_

Explain "Yes" answers below:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	1. Have you ever been told you have a heart murmur?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	2. Have you ever been treated for a condition or abnormality of the heart or circulatory system? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	3. Have you ever had high blood pressure?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. Have you ever had racing of your heart or skipped heartbeats?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	5. Has anyone in your family died of heart problems or a sudden death before age 50?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6. Have you had any illness requiring bed rest of one week or longer during the past 18 months? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	7. Have you ever been "knocked out" or experienced a concussion during the past three years? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. Have you ever passed out in the heat?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	9. Have you ever had any injury to your neck or spinal cord involving nerves, vertebrae (bones) or disks? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	10. Do you have any known visual impairment? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	11. If you wear glasses or contact lenses, do you wear them during activity?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	12. Do you wear any dental appliance during activity? If yes, please name the appliance worn.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	13. Have you had any fractures, including stress fractures, during the past two years? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	14. Have you had a dislocation, subluxation or separation of a joint during the past two years? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	15. Have you ever had an injury to your back? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	16. Have you ever had an injury to your knee(s) involving ligaments or cartilage? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	17. Have you ever been advised to have surgery to correct a knee condition? If yes, was surgery completed? Give date.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	18. Have you ever been advised to have surgery to correct a shoulder condition? If yes, was surgery completed? Give date.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	19. Have you experienced a severe sprain of either ankle during the past two years?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	20. Do you have a pin, screw or plate somewhere in your body as a result of bone or joint surgery? If yes, indicate anatomical site and date of surgery.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	21. Have you ever been told you have a hernia? If yes, has the hernia been repaired?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	22. Have you had any additional surgery or serious illness, injuries or health problems not previously addressed in this medical history? If yes, give details.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	23. What medications/supplements do you take (i.e. prescription, over-the-counter, herbal, non-traditional, protein, creatine, etc.)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	24. Are you allergic to any food or medication? If yes, give details of food(s) or medication(s).
<input type="checkbox"/> Yes	<input type="checkbox"/> No	25. Have you ever or do you now have asthma? If so, do you use an inhaler?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	26. Do you have a life-threatening allergy to insect stings?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	27. Have you had a medical problem or injury since your last sports evaluation?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	28. Is any paired organ (kidney, eye, testicle) missing or not functioning?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	29. Do you have sickle cell trait?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	30. Have you ever been diagnosed with Malaria or dengue fever? If yes, which _____ Date: _____
		31. Women only: What was the longest time between your periods last year? _____

Explain "Yes" answers: \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. I give permission for the exchange of information regarding my physical condition and health between the Athletic Training staff, Athletic Department staff, and Goshen Family Physicians. This release is in effect for the period of time that I am involved in any sport at Goshen College.

Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_

**Preparticipation Physical Evaluation** *continued*

Name: \_\_\_\_\_

Subjective:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_ Pulse: \_\_\_\_\_  
 Vision: **R** 20/\_\_\_\_\_ **L** 20/\_\_\_\_\_ Corrected: **Y** **N** Pupils (Circle) Equal/Unequal R>L L>R Last Td Date: \_\_\_\_\_

	Normal	Abnormal Findings	Initials
<b>Cardiopulmonary</b>			
Pulses			
Heart			
Lungs			
<b>Skin</b>			
<b>Abdominal</b>			

	Strength 1 – 3	Flexibility 1 – 3	Abnormal Findings	Initials
<b>Musculoskeletal</b>				
Neck				
Shoulder				
Upper Arm				
Forearm / Hand				
Upper Back				
Lower Back				
Hip				
Quadriceps				
Hamstrings				
Lower Leg				
Ankle / Foot				
<b>Joint Stability</b>				
Ankle				
Knee				
Shoulder				

Strength 1 = poor 2 = fair 3 = normal Flexibility 1 = poor 2 = fair 3 = normal

Clearance:

- A. Cleared No restrictions
  - B. Cleared after completing evaluation/examination for: \_\_\_\_\_
  - C. Not cleared for Collision Contact Noncontact
- Due to: \_\_\_\_\_

Plan:

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonable be anticipated to render this athlete physically unfit to engage in any sport, **except those listed here:** \_\_\_\_\_

Name of Examiner (*Please Print*): \_\_\_\_\_ MD, DO, NP, PA

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_