

ATHLETES SCREENING PHYSICAL EXAM RECORD

NAME: _____	AGE: _____	DATE OF BIRTH _____
SS# _____	MALE/FEMALE _____	SPORT: _____
HOME ADDRESS: _____	LOCAL ADDRESS: _____	
_____	_____	
_____	_____	

	Yes	No
1. Have you ever passed out? If yes, give date and explain _____	O	O

Had a concussion? If yes, give date and explain _____	O	O

Had a seizure? If yes, give date and explain _____	O	O

Had a stinger/brachial plexus injury? If yes, give date and explain _____	O	O

2. Have you ever been told you have a heart murmur?	O	O
3. Have you ever passed out during or after exercise?	O	O
4. Have you ever had chest pain during or after exercise?	O	O
5. Do you get tired more quickly than your friends do during exercise?	O	O
6. Have you ever had a racing of your heart or skipped heart beats?	O	O
7. Have you had high blood pressure or high cholesterol?	O	O
8. Has any family member or relative died of heart problems or sudden death before age 50?	O	O
9. Has a physician ever denied or restricted your participation in sports for any heart problems?	O	O
10. Have you had mononucleosis, myocarditis, hepatitis, been ill (other than colds), or have been hospitalized in the past 6 months? If yes, explain: _____	O	O

11. Have you ever had		
a. a broken bone in the last year?	O	O
b. any knee injuries?	O	O
c. any elbow injuries?	O	O
d. a dislocated or separated shoulder?	O	O
e. an ankle injury?	O	O
12. Have you ever had any illness, condition, or injury that		
a. required you to go to the hospital either as a patient overnight or in emergency room for x-rays?	O	O
b. required an operation?	O	O
c. caused you to miss a game or practice?	O	O
d. is related to allergies (hay fever, hives, asthma, or medicine)?	O	O
13. Do you have		
a. diabetes	O	O
b. bleeding tendency	O	O
c. sickle cell anemia	O	O
d. kidney disease	O	O
e. asthma	O	O
f. heat illness/exhaustion or heat stroke	O	O
If yes on any of the above, please explain _____		

14. Are you currently taking any medication? If yes, what _____	O	O

15. Do you wear any dental appliance? _____	O	O

I certify that the above information is both true and complete to the best of my knowledge, and I understand I am completely and wholly liable for any losses sustained as a result of withholding medical information.

Athlete's Signature: _____ **Date:** _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION

NAME: _____	DATE OF BIRTH: _____
HEIGHT: _____	WEIGHT: _____
PULSE: _____	BP: _____/_____(____/____,____/____)
VISION R 20/____ L 20/____	CORRECTED: YES/NO _____ PUPILS: EQUAL _____ UNEQUAL _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
1. Precordial Auscultation (Supine & Standing)			
2. Marfan Syndrome			
3. Assessment of femoral artery			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Knee			
Leg/Ankle			
Foot			

<u>CLEARANCE</u>	
Cleared for participation	
Cleared after completing evaluation/rehabilitation for:	_____
Not cleared for:	_____ Reason: _____
RECOMMENDATIONS: _____	
NAME OF PHYSICIAN (PRINT/TYPE) _____	DATE: _____
ADDRESS: _____	PHONE: _____
SIGNATURE OF PHYSICIAN: _____, MD or DO	