Clarke Central Pre-Participation Physical Evaluation

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ Phone (W) _____

MEDICAL HISTORY SECTION (Explain "YES" answers below. Circle questions to which you don't know the answer.)

	YES	NO
1. Has the doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes)?	☐	☐
3. Are you currently taking any prescription or non-prescription (over the counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, food or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has your doctor ever told you that you have any heart problems?	☐	☐
10. Has your doctor ever ordered a test for your heart (i.e. ECG, echocardiogram, etc.)?	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before the age of 50?	☐	☐
14. Does anyone in your family have Mar fans syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had a stress fracture?	☐	☐
18. Do you regularly use a brace or assistive device?	☐	☐
19. Have you ever had a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?	☐	☐
20. Have you ever had any broken or fractured bones or dislocated joints?	☐	☐
21. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches?	☐	☐

If you answered yes to any of the above, circle the affected area below.

Head	**Neck**	**Shoulder**	**Upper Arm**	**Lower Arm**	**Forearm**	**Hand/ Finger**	**Chest**
Upper Back	**Lower Back**	**Hip**	**Thigh**	**Knee**	**Calf/ Shin**	**Ankle**	**Foot/ Toes**

	YES	NO
22. Have you ever been told that you have or have you ever had an x-ray for atlantoaxail (neck) instability?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medication?	☐	☐
27. Were you born without or are you missing a kidney, eye, testicle or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have rashes, pressure sores or other skin problems?	☐	☐
30. Have you ever had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you ever been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
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. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor ever told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you ever has any problems with your eye or vision?	☐	☐
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear such as goggle or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?		
44. Has anyone ever recommended you to change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐

If you answered "YES" to any of the above questions, please explain here: _____

_____

_____

Do you have any additional concerns you would like to discuss with the doctor? If so, please note here:_____

_____

_____

FEMALES ONLY

Have you ever had a menstrual period? YES/NO (Please circle one)

If so, at what age was your first menstrual period? _____ How many periods have you had in the last 12 months? _____

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

Signature of Athlete _____ **Signature of Parent/Guardian** _____ **Date** _____

PHYSICAL EXAMINATION SECTION

Name_____ Date of Birth_____

Height_____ Weight _____ % Body Fat (optional) _____ Pulse _____ B/P _____/_____ (___/___, ___/___)

Vision R20/ _____ L20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials
Medial			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only) +			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Finger			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

* Multiple examiner set-up only
+ Having a third party present is recommended for the genitourinary examination

Notes: _____

☐ Cleared without restriction

☐ Cleared, with recommendations for further evaluation or treatment for: _____

_____

_____

☐ Not cleared for ☐ All sports ☐ Certain Sports: _____ Reason: _____

Recommendations: _____

_____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of Physician (Print/Type) _____ Date _____

Address _____ Phone _____

Signature of Physician _____ **MD OR DO** **Date of Exam** _____