

**COMGRI.COM "Patients Come First"**

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**PREPARTICIPATION PHYSICAL EVALUATION**

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

Address \_\_\_\_\_ Phone \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Sports \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Personal Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

**Medical History Questionnaire - This section must be completed before your examination. Include dates of any problems and explain all yes answers. Please sign in appropriate spaces below.**

- |  | YES                      | NO                       |   | YES                      | NO                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Are you currently under a doctor's care for any reason?   | <input type="checkbox"/> | <input type="checkbox"/> | 18. Do you wear glasses or contacts or protective eye wear?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized?  | <input type="checkbox"/> | <input type="checkbox"/> | 19. Do you use any special equipment (splints, neck rolls, mouth guards, etc.)?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 20. Has anyone in your family died of heart problem or sudden death before the age of 50?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking an medications or pills?   | <input type="checkbox"/> | <input type="checkbox"/> | 21. Do you have only one working organ of usually paired organs (only one eye, kidney, etc.)?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergies (medicines, bee stings, etc.)?  | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have you ever sprained, broken, dislocated or had repeated swelling or pain of any bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been dizzy or fainted during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have you ever had a stinger, burner or pinched nerve?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had chest pains during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you had any medical problems or injuries? (asthma, mono, diabetes, etc.)                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had high blood pressure?  | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have you had any medical problems or injuries since your last evaluation?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been told you have a heart murmur?  | <input type="checkbox"/> | <input type="checkbox"/> | 26. Were there any special instructions or precautions given by the Medical Practitioner?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had a racing heart or skipped heartbeats?  | <input type="checkbox"/> | <input type="checkbox"/> | 27. What was the date of your last tetanus shot: _____  |                          |                          |
| 11. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> | 28. Do you have Sickle Cell Trait or Sickle Cell Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been knocked unconscious?  | <input type="checkbox"/> | <input type="checkbox"/> | 29. (Women Only) Date of first menstrual period: _____  |                          |                          |
| 13. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> | Date of your last menstrual period: _____   |                          |                          |
| 14. Are any of the following currently bothering you?<br>Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/><br>Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Foot <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | What was the longest period of time between your periods last year? _____                               |                          |                          |
| 15. Have you ever been dizzy or passed out due to the heat?  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 16. Do you have trouble breathing before or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 17. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

**Explain all "Yes" answers by question number and indicate dates for each item (include any special instructions):**

\_\_\_\_\_

**I/We hereby state that, to the best of my/our knowledge, the answers to the above questions are correct. I/We understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this individual.**

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

Signature of Parent or Guardian (if athlete is under 18) \_\_\_\_\_ Date \_\_\_\_\_

	Blood Pressure	HEENT	Skin	Heart	Lungs	Abdomen	Flexibility/Strength
NORMAL							
ABNORMAL							

While this does not constitute a complete physical examination nor replace the need for periodic health evaluations by a family physician, this individual appears to be physically capable of participation in interscholastic sports as of this date, except as indicated below.

- Cleared for sports without restrictions
- Cleared with the following restrictions: \_\_\_\_\_
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- Not Cleared

At this athlete's screening exam, the following is/are noted:

Condition/Sign/Symptoms with Simple Explanation/Recommendations

- Elevated (High) Blood Pressure. Increase in pressures in the artery during the beating and resting heart. Maximum normal (age group) \_\_\_/\_\_\_
- Heart Murmur. Flow of blood through the heart which is audible. In this case, it is:  "Functional" (normal)  Abnormal.
- Asthma. Blockage of small airways in the lung.  Use inhaler as prescribed and 30 minutes before exercise.
- Allergic Reactions to Stings or Bites. (includes whole body swelling & shortness of breath)  Epinephrine injector should be available at all times.
- Diabetes. Abnormal sugars and sugar metabolism.  Continue close monitoring with M.D.
- Scoliosis. Curvature of the spine.  Continue close monitoring with M.D.
- Orthopaedic Problem. Being seen by M.D. for this condition.  Should be cleared for play by M.D.
- Concussion. Further evaluation required before athletic participation permitted.
- Other: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_