



Preparticipation Physical Evaluation Form

***Please explain any yes answers below.**

	YES	NO
1. Have you had a medical illness or injury since your last check up or sport physical?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has a physician ever denied or restricted your participation in sports for any health problems?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have any current skin problems (for example itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
25. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
27. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you use special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
31. Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
34. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
35. Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
36. Do you feel stressed?	<input type="checkbox"/>	<input type="checkbox"/>
37. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check the appropriate box:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Foot <input type="checkbox"/> Neck <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee <input type="checkbox"/> Back <input type="checkbox"/> Elbow <input type="checkbox"/> Finger <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Ankle		

Please explain: _____

38. Record the dates of your most recent immunizations (shots):
 Tetanus: _____ Measles: _____
 Hepatitis B: _____ Chickenpox: _____

FEMALES ONLY

39. When was your first menstrual period? _____
 40. When was your most recent menstrual period? _____
 41. How much time do you usually have from the start of one period to the start of another? _____
 42. How many periods have you had in the last year? _____
 43. What is the longest time between periods in the last year? _____

Explain "YES" answers here: _____

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

Name _____ Date of birth _____ RU ID _____

Signature of athlete, parent or guardian _____ Date _____

Physical must be performed by a physician recognized by the American Medical Association.
Physicals given by chiropractors will not be accepted.

Clinic Use Only

Name _____

Height _____ Weight _____ % Body Fat (Optional) _____

Pulse _____ BP _____ / _____ (_____ / _____ _____ / _____)

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

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance	<input type="checkbox"/>	_____
Eyes /Ears /Nose /Throat	<input type="checkbox"/>	_____
Lymph Nodes	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	_____
Pulses	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	_____
Genitalia (males only)	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	_____
MUSCULOSKELETAL		
HEAD	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	_____
Back	<input type="checkbox"/>	_____
Shoulder /arm	<input type="checkbox"/>	_____
Elbow /forearm	<input type="checkbox"/>	_____
Wrist /hand	<input type="checkbox"/>	_____
Hip (thigh)	<input type="checkbox"/>	_____
Knee	<input type="checkbox"/>	_____
Leg /ankle	<input type="checkbox"/>	_____
Foot	<input type="checkbox"/>	_____

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Physician Name: _____ Phone _____

Physician Signature _____ Date _____