

Preparticipation Physical Evaluation

History

Date of Exam _____

Name _____ Sex _____ Age _____ Date of Birth _____

Sport(s) _____ Personal Physician _____

Address _____ Phone _____

Circle questions you do not know the answer to .Explain yes answers below.

	yes	no		yes	no																		
1. Have you had a medical illness or injury since your last check-up or sports physical ?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you cough,wheeze or have trouble breathing during or after exercise? Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>																		
2. Have you ever been hospitalized over night? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>																		
3. Are you currently taking any prescription or non prescription (over the counter) medications or pills or using an inhaler? 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"/>	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example,knee brace, special neck roll,foot orthotics,retainer on your teeth or hearing aid?)	<input type="checkbox"/>	<input type="checkbox"/>																		
4. Do you have any allergies (for example to pollen,medicine,food or stinging insects)? Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>																		
5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats ? Have you ever had high blood pressure of high cholesterol? Have you ever been told you have a heart murmur? Has any family member of relative died of heart problems or of a sudden death before age 50? Have you ever had a severe viral infection (for example myocarditis or mononucleosis)within the past month? Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain,strain,or swelling after an injury? Have you ever broken or fractured any bones or dislocated any joints? Have you had any problems with pain or swelling in muscles,tendons,bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>																		
6. Do you have any current skin problems(for example,rashes,acne,warts,fungus or blisters)	<input type="checkbox"/>	<input type="checkbox"/>	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Head</td> <td style="width: 33%;">Elbow</td> <td style="width: 33%;">Thigh</td> </tr> <tr> <td>Neck</td> <td>Forearm</td> <td>Knee</td> </tr> <tr> <td>Back</td> <td>Wrist</td> <td>Shin/calf</td> </tr> <tr> <td>Chest</td> <td>Hand</td> <td>Ankle</td> </tr> <tr> <td>Shoulder</td> <td>Finger</td> <td>Foot</td> </tr> <tr> <td>Upper arm</td> <td>Hip</td> <td></td> </tr> </table>	Head	Elbow	Thigh	Neck	Forearm	Knee	Back	Wrist	Shin/calf	Chest	Hand	Ankle	Shoulder	Finger	Foot	Upper arm	Hip			
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Back	Wrist	Shin/calf																					
Chest	Hand	Ankle																					
Shoulder	Finger	Foot																					
Upper arm	Hip																						
7. Have you ever had a head injury or concussion? Have you ever been knocked out,become unconscious, or lost your memory? Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	If yes circle appropriate area and explain below																				
Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>																		
Have you ever had a stinger,burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>																		
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	Females Only																				
			15. When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the past year? _____ What was the longest time between periods in the past 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.I also give my permission to share this history and physical with the athletic department.

Date _____

**UMASS DARTMOUTH
Preparticipation Physical Evaluation**

Physical Examination

Name _____ SSN _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____
 Vision Right _____ Left _____ Both _____

	Normal	Abnormal Findings
MEDICAL		
Appearance		
EENT		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		
MARFAN'S SCREEN IF HEIGHT IS 5'10 OR GREATER		
Wrist Sign		
Thumb Sign		
Arm Span >1.05		
High arched palate		

CLEARANCE

Cleared _____ Cleared after completing evaluation/rehabilitation for _____

Not Cleared for: _____ Reason: _____

Recommendations: _____

Name of Health Provider (print) _____ Date _____

Signature _____ Title _____