

**PREPARTICIPATION EVALUATION**

**PHYSICAL EXAMINATION FORM**

NAME: \_\_\_\_\_ SPORT(S): \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ PULSE: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )

VISION: R 20/\_\_\_\_ L 20/\_\_\_\_ CORRECTED: Y N If Yes, Glasses \_\_\_\_ Contacts \_\_\_\_ PUPILS: EQUAL \_\_\_\_ UNEQUAL \_\_\_\_

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; pneumococcal; meningococcal; varicella)

Up to date \_\_\_\_\_ Not up to date \_\_\_\_\_ Specify \_\_\_\_\_

**Follow-Up Questions on More Sensitive Issues**

1. Do you feel stressed out or under a lot of pressure? ..... Y N
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?..... Y N
3. Do you feel safe? ..... Y N
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? ..... Y N
5. During the past 30 days, did you use chewing tobacco, snuff, or dip? ..... Y N
6. During the past 30 days, have you had at least 1 drink of alcohol? ..... Y N
7. Have you ever taken steroid pills or shots without a doctor's prescription? ..... Y N
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance? ..... Y N
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc. .... Y N

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)**			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/Toes			

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

\_\_\_\_\_ Cleared without restriction

\_\_\_\_\_ Not cleared for \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of physician (print/type): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of physician: \_\_\_\_\_, MD or DO