Pre-Participation Athletic Evaluation- History

Name:________________________________ Date of Birth:________________

Address:______________________________ Telephone:__________________

Family M.D._________________

In Case of Emergency, please notify:___________________________________

Address:________________________________

Telephone:________________________________

Date of last tetanus booster:__________________________

Date of last examination by a Doctor:__________________________________

The following questions are to be answered by either yes or no. Please check the appropriate space.

	Yes	No
Have you been under a doctor's care in the last 12 months		
Have you been in the hospital within the last 12 months		
Have you ever had any type of surgery?		
Do you want to talk to a doctor about a health problem or injury?		
Diabetes (high sugar in blood)		
Allergies (hay fever or asthma)		
Migraines/headaches		
Heart trouble		
High Blood Pressure		
Has anyone in your family under 50 died suddenly?		
Have you had or do you now have:		
Brain concussion (head injury)?		
Tendency to lose consciousness (faint)?		
Skull Fracture?		
Convulsions or Epilepsy?		
Neck injury?		
Have you had or do you now have:		
Very bad (impaired) vision in one eye?		
Temporary loss of vision?		
Wear glasses or contacts?		

	Yes	No
Have you had or do you have now:		
Hearing loss?		
Perforated eardrum?		
Discharge from ear(s) (recurrent infections)?		
Sinus infections?		
Broken nose?		
Dental Plate (dentures)?		
Orthodontia (teeth straitened)		
Have you had or do you have now?		
Hernia?		
Kidney Problem?		
Loss of function or absence of testicles (BOYS)?		
Menstrual problems(GIRLS)?		
Have you had or do you have now?		
Bone fracture?		
Joint dislocation?		
Foot problems?		
To wear a cast?		
Have you had or do you have now?		
Back injury or frequent backaches?		
Knee injury(sprain) or recurrent pain?		
Ankle injury(sprain) or recurrent pain?		
Other joint problems?		
Bone infections?		
Have you had or do you have now?		
Diabetes?		
Tendency to bleed or bruise easily?		
Anemia?		
Weight problems (under or overweight)?		

	Yes	No
Have you had or do you have now?		
Asthma?		
Hay fever?		
Hives or Rash?		
Bee sting reactions (allergy)?		
Reaction to medicine (allergy)?		
Do you Smoke?		
Take any medication regularly?		
Take any medication for emergency use?		
Have you had or do you have:		
Heart trouble or murmur?		
High blood Pressure?		
Persistent Cough?		
Chest pain while exercising?		
Have you had or do you now have?		
Recurrent rashes?		
Fungus infections?		
Athletes foot?		
Recurrent boils (skin infections)?		
Do you wish to discuss an emotional problem with the doctor?		
Have you ever been told to give up sports due to a health problem?		

If you answered yes to any of the questions please explain below:

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Name:_________________________________ Date:__________________________

Height:______________________ BP:________________ Vision: L 20/ R 20/

Weight:______________________

	Normal	Abnormal	Physical Evaluation Comments
Eyes			
Ears, Nose and Throat			
Mouth and Teeth			
Neck			
Lymphatics			
Respiratory			
Cardiovascular			
Abdomen			
Genitalia-Hernia			
Sexual Maturity			
Skin			
Cervical Spine			
Back			
Shoulders			
Arm and Hands			
Hips			
Thighs			
Knees			
Ankles			
Feet			
Neurological			

Summary of Comments:

Recommendations:

__________________ Athlete can fully participate

__________________ No participation until __________

__________________ Conditional Participation Limited to __________

__________________ No Participation

Physician's Signature___________________________ Date________________________