

PREPARTICIPATION MEDICAL EVALUATION FORM

Personal History

Name _____ Social Security# _____

SEX: Male / Female Age _____ Date of Birth _____ Grade _____

School _____ Activity _____ Marching Band

Personal Physician _____ Address _____ Phone _____

Have you ever had a preparticipation physical before? _____ Yes _____ No If yes, when/where _____

Please explain "Yes" answers below.

- | | | |
|--|---------|----|
| 1. Have you ever been hospitalized? | 1. YES | NO |
| 2. Have you ever had surgery? | 2. YES | NO |
| 3. Are you currently taking any medications or pills? | 3. YES | NO |
| 4. Do you have allergies? (medicine, foods, bees, or other stinging insects) | 4. YES | NO |
| 5. Have you ever passed out during exercise? | 5. YES | NO |
| 6. Have you ever been dizzy during or after exercise? | 6. YES | NO |
| 7. Have you ever had chest pain during exercise? | 7. YES | NO |
| 8. Do you tire more quickly than your friends during exercise? | 8. YES | NO |
| 9. Have you ever had high blood pressure? | 9. YES | NO |
| 10. Have you ever been told that you have a heart murmur? | 10. YES | NO |
| 11. Has anyone in your family died of heart problems or a sudden death before the age of 50? | 11. YES | NO |
| 12. Do you have any skin problems? (itching, rashes, acne) | 12. YES | NO |
| 13. Have you ever had a head injury? | 13. YES | NO |
| 14. Have you ever been knocked unconscious? | 14. YES | NO |
| 15. Have you ever had a seizure? | 15. YES | NO |
| 16. Have you ever had a stinger, burner, or pinched nerve? | 16. YES | NO |
| 17. Have you ever had heat or muscle cramps? | 17. YES | NO |
| 18. Have you ever been dizzy or passed out from the heat? | 18. YES | NO |
| 19. Do you have trouble breathing, cough during or after activities or have been diagnosed with asthma? | 19. YES | NO |
| 20. Do you use any special equipment? (pads, braces, neck roll, mouth guard, eye guard) | 20. YES | NO |
| 21. Have you had any problems with your eyes or vision? | 21. YES | NO |
| 22. Do you wear glasses or contacts or protective eyewear? | 22. YES | NO |
| 23. Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling of any bones or joints? | | |

Head _____ Shoulder _____ Thigh _____ Neck _____ Elbow _____ Knee _____ Chest _____
Forearm _____ Shin/Calf _____ Foot _____ Back _____ Wrist _____ Ankle _____ Hip _____ Hand _____

- | | | |
|--|---------|----|
| 24. Have you had any other medical problem? (infectious mononucleosis, diabetes) | 24. YES | NO |
| 25. Have you had a medical problem since your last evaluation? | 25. YES | NO |
| 26. When was your last tetanus shot? _____ | | |
| 27. When was your last measles shot? _____ | | |

(FEMALE ONLY)

- | | | |
|---|--|--|
| 28. When was your first menstrual period? _____ | | |
| 29. When was your last Menstrual period? _____ | | |
| 30. When was the longest time between your periods last year? _____ | | |

Please explain "YES" answers here:

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

Student Signature

Parent Signature

Date

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20/ _____ L 20/ _____ Corrected? _____ Yes _____ No Pupils _____

Musculoskeletal Examination

	Normal	Abnormal Findings
Neck / Back	_____	_____
Upper Extremities	_____	_____
Lower Extremities	_____	_____
Flexibility	_____	_____

General Examination

	Normal	Abnormal Findings
Ears, Nose and Throat	_____	_____
Heart	_____	_____
Chest / Lungs	_____	_____
Skin / Lymphatic	_____	_____
Abdominal	_____	_____
Genitalia / Hernia	_____	_____

A. This individual _____ may _____ may not participate based on the data gathered from this exam.

B. Prior to participation, treatment or follow-up on the following is recommended:

Official Recommendation

C. Recommend further consultation with

Signature of Physician

Date