



# Pre-participation Examination



## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_

Last \_\_\_\_\_

First \_\_\_\_\_

Middle \_\_\_\_\_

EXAMINATION			
Height _____	Weight _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP _____ / _____ ( _____ / _____ )	Pulse _____	Vision R 20/ _____	L 20/ _____
		Corrected <input type="checkbox"/> Y <input type="checkbox"/> N	
<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	
Appearance <ul style="list-style-type: none"><li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li></ul>			
Eyes/ears/nose/throat <ul style="list-style-type: none"><li>Pupils equal</li><li>Hearing</li></ul>			
Lymph nodes			
Heart <sup>a</sup> <ul style="list-style-type: none"><li>Murmurs (auscultation standing, supine, +/- Valsalva)</li><li>Location of point of maximal impulse (PMI)</li></ul>			
Pulses <ul style="list-style-type: none"><li>Simultaneous femoral and radial pulses</li></ul>			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin <ul style="list-style-type: none"><li>HSV, lesions suggestive of MRSA, tinea corporis</li></ul>			
Neurologic <sup>c</sup>			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/Ankle			
Foot/toes			
Functional <ul style="list-style-type: none"><li>Duck-walk, single leg hop</li></ul>			

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes \_\_\_\_\_ No \_\_\_\_\_ Limited \_\_\_\_\_ Examination Date \_\_\_\_\_

Additional Comments:

Physician's Signature \_\_\_\_\_

Physician's Name \_\_\_\_\_

Physician's Assistant Signature\* \_\_\_\_\_

PA's Name \_\_\_\_\_

Advanced Nurse Practitioner's Signature\* \_\_\_\_\_

ANP's Name \_\_\_\_\_

\*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.



# Pre-participation Examination



To be completed by athlete or parent prior to examination.

Name \_\_\_\_\_ School Year \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ City/State \_\_\_\_\_

Phone No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Class \_\_\_\_\_ Student ID No. \_\_\_\_\_

Parent's Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

## HISTORY FORM

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.  
☐ Medicines ☐ Pollens

☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

### GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No

2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections  
Other: \_\_\_\_\_

3. Have you ever spent the night in the hospital? Yes No

4. Have you ever had surgery? Yes No

### HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out DURING or AFTER exercise? Yes No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Yes No

7. Does your heart ever race or skip beats (irregular beats) during exercise? Yes No

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease  
Other: \_\_\_\_\_

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) Yes No

10. Do you get lightheaded or feel more short of breath than expected during exercise? Yes No

11. Have you ever had an unexplained seizure? Yes No

12. Do you get more tired or short of breath more quickly than your friends during exercise? Yes No

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? Yes No

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? Yes No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Yes No

### BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? Yes No

18. Have you ever had any broken or fractured bones or dislocated joints? Yes No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Yes No

20. Have you ever had a stress fracture? Yes No

21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) Yes No

22. Do you regularly use a brace, orthotics, or other assistive device? Yes No

23. Do you have a bone, muscle, or joint injury that bothers you? Yes No

24. Do any of your joints become painful, swollen, feel warm, or look red? Yes No

25. Do you have any history of juvenile arthritis or connective tissue disease? Yes No

### MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No

27. Have you ever used an inhaler or taken asthma medicine? Yes No

28. Is there anyone in your family who has asthma? Yes No

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? Yes No

30. Do you have groin pain or a painful bulge or hernia in the groin area? Yes No

31. Have you had infectious mononucleosis (mono) within the last month? Yes No

32. Do you have any rashes, pressure sores, or other skin problems? Yes No

33. Have you had a herpes or MRSA skin infection? Yes No

34. Have you ever had a head injury or concussion? Yes No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? Yes No

36. Do you have a history of seizure disorder? Yes No

37. Do you have headaches with exercise? Yes No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No

39. Have you ever been unable to move your arms or legs after being hit or falling? Yes No

40. Have you ever become ill while exercising in the heat? Yes No

41. Do you get frequent muscle cramps when exercising? Yes No

42. Do you or someone in your family have sickle cell trait or disease? Yes No

43. Have you had any problems with your eyes or vision? Yes No

44. Have you had any eye injuries? Yes No

45. Do you wear glasses or contact lenses? Yes No

46. Do you wear protective eyewear, such as goggles or a face shield? Yes No

47. Do you worry about your weight? Yes No

48. Are you trying to or has anyone recommended that you gain or lose weight? Yes No

49. Are you on a special diet or do you avoid certain types of foods? Yes No

50. Have you ever had an eating disorder? Yes No

51. Have you or any family member or relative been diagnosed with cancer? Yes No

52. Do you have any concerns that you would like to discuss with a doctor? Yes No

### FEMALES ONLY

53. Have you ever had a menstrual period? Yes No

54. How old were you when you had your first menstrual period? Yes No

55. How many periods have you had in the last 12 months? Yes No

Explain "yes" answers here

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_