

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

### Follow-Up Questions on More Sensitive Issues

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel safe?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 30 days, did you use chewing tobacco, snuff, or dip?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 30 days, have you had at least 1 drink of alcohol?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Questions from the Youth Risk Behavior Survey ( <a href="http://www.cdc.gov/HealthyYouth/yrbs/index.htm">http://www.cdc.gov/HealthyYouth/yrbs/index.htm</a> ) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc. | <input type="checkbox"/> | <input type="checkbox"/> |

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>†</sup>			
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.

Notes: \_\_\_\_\_  
 \_\_\_\_\_

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

Address \_\_\_\_\_ Phone \_\_\_\_\_

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