

# Birmingham Public Schools Preparticipation Physical Evaluation

**HISTORY**

DATE OF EXAM \_\_\_\_\_

A current-year physical is one given on or after April 15 of the previous school year.

Name _____		Sex _____	Age _____	Date of birth _____
Grade _____	School _____	Sports _____		
Address _____			Phone _____	
Personal physician _____				
<i>In case of emergency, contact</i>				
Name _____		Relationship _____	Phone (H) _____	(W) _____

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

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over the counter medications) or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check appropriate box and explain below.</i>		
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip		
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh		
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee		
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/calf		
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm <input type="checkbox"/> Foot		
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the date of your most recent immunizations (if known) for:		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____		
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALES ONLY</b>		
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	16. When was your first menstrual period? _____		
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start on another? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
Have you ever had numbness or tingling in your arms, hands legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between in the last year _____		
8. Have you ever had a stinger, burn, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Explain "Yes" answers here:</b> _____		
9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

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 \_\_\_\_\_

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION

Name _____		Date of birth _____	
Height _____	Weight _____	% Body fat (optional) _____	Pulse _____ BP _____/_____/_____ (_____/_____, ____/____)
Vision R 20/ _____	L 20/ _____	Corrected: Y N	Pupils: Equal _____ Unequal _____

NORMAL	ABNORMAL FINDINGS	INITIALS
<b>MEDICAL</b>		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (Males only)		
Skin		
<b>MUSCULOSKELETAL</b>		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

\* Station based examination only

## CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Not Cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Name of Physician (Print/Type) \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of Physician \_\_\_\_\_ MD or DO