

Pre-Participation Physical Evaluation – Gahr High School

Student History – Home Phone/Cell _____ **Date of Exam** _____

Name _____ Sex _____ Age _____ Grade _____ Date of Birth _____
LAST NAME FIRST NAME

Sport(s) Interested in Participating _____

Home Address _____ City _____ Zip Code _____

Personal physician _____

Contact Emergency:

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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury?	<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 broken or fractured any bones or dislocated any 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"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.		
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Have you ever been dizzy 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 had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder		<input type="checkbox"/> Upper arm
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Finger
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Ankle
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Foot
Has any family member or relative died of heart problems or of sudden death before age 50?	<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 a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunizations (shots) for:		
7. Have you ever had a head Injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____		
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
Do you have frequent or sever headaches?	<input type="checkbox"/>	<input type="checkbox"/>	16. When was your first menstrual period?	_____	
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period?	_____	
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another?	_____	
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year?	_____	
9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year?	_____	
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Explain “YES” answers here:	_____	
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 _____

Pre-Participation Physical Evaluation – Gahr High School

PHYSICAL EXAMINATION

Date of Exam _____

Name _____ Sex _____ Age _____ Date of Birth _____
LAST NAME FIRST NAME

Height _____ Weight _____ % Body fat (Optional) _____ Pulse _____ BP ____/____/____/____/____

Vision R 20/ _____ L 20/ _____ Corrected: **Yes** **No** Pupils Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrest/hand			
Hip (thigh)			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

CLEARANCE

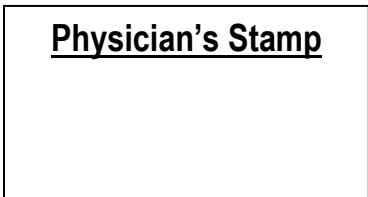
- Cleared
- Cleared after completing evaluation/rehabilitation for _____

Not Cleared for _____ Reason _____

Recommendations _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____



_____, MD, Do, PAC, RNP, or DC
SIGNATURE OF PHYSICIAN