BELL SPORTS MEDICINE INSTITUTE

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Preparticipation Physical Evaluation

Name:	Age: Date of Birth: ☐ Male ☐ Female
School: Grade in school:	Sport(s):
Home Address:	Home phone:
City/State/Zip:	Cell Phone:
Name of Parents/Guardian:	Personal Physician:
Parents/Guardian Phone:	MD's Phone:

Medical History: Fill out as best as you can, and explain any "Yes" answers below:

#	Question	Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Do you have an ongoing chronic illness	☐	☐
3.	Have you ever been hospitalized overnight?	☐	☐
4.	Have you ever had surgery?	☐	☐
5.	Are you currently taking any prescription or non-prescription (over-the-counter) pills or medications, or using an inhaler?	☐	☐
6.	Are you currently taking any vitamins or supplements to help you gain or lose weight or help your performance?	☐	☐
7.	Do you have any allergies (for example, to pollen, medications, food or insect bites)?	☐	☐
8.	Have you ever had a rash or hives develop during or after exercise?	☐	☐
9.	Have you ever passed out during or after exercise?	☐	☐
10.	Have you ever been dizzy during or after exercise?	☐	☐
11.	Have you ever had chest pain during or after exercise?	☐	☐
12.	Do you get tired more quickly than your friends do during exercise?	☐	☐
13.	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
14.	Have you every had high blood pressure or high cholesterol?	☐	☐
15.	Have you ever been told you have a heart murmur?	☐	☐
16.	Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐
17.	Have you ever had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	☐	☐
18.	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
19.	Do you have any current skin problems (for example itching, rashes, acne, warts, fungus or blisters)?	☐	☐
20.	Have you ever had a head injury or concussion?	☐	☐
21.	Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
22.	Have you ever had a seizure?		
23.	Do you have frequent or severe headaches?	☐	☐
24.	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
25.	Have you ever had a stinger, burner or pinched nerve?	☐	☐

#	Question	Yes	No
26.	Have you ever become ill from exercising in the heat?	☐	☐
27.	Do you cough, wheeze or have trouble breathing during of after activity?	☐	☐
28.	Do you have asthma?	☐	☐
29.	Do you have seasonal allergies that require medical treatment?	☐	☐
30.	Do you use any special or corrective equipment or devices that aren't usually used for your sport or positions (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth or hearing aid)?	☐	☐
31.	Have you had any problems with your eyes or vision?	☐	☐
32.	Do you wear glasses, contacts or protective eyewear?	☐	☐
33.	Have you ever had a sprain, strain or swelling after injury? If yes, explain below.	☐	☐
34.	Have you broken or fractured any bones or dislocated any joints?	☐	☐
35.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, mark and explain below: ☐ Head ☐ Elbow ☐ Thigh ☐ Neck ☐ Forearm ☐ Knee ☐ Back ☐ Wrist ☐ Shin/Calf ☐ Chest ☐ Hand ☐ Ankle ☐ Shoulder ☐ Finger ☐ Foot ☐ Upper Arm ☐ Hip ☐ Other:	☐	☐
36.	Do you want to weigh more or less than you do now?	☐	☐
37.	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
38.	Do you feel stressed out?	☐	☐
39.	Record the dates of your most recent immunizations (shots) for: Tetanus: Measles: Hepatitis B: Chickenpox:	☐	☐
	FEMALES ONLY (optional):	☐	☐
40.	When was your first menstrual period?	☐	☐
41.	When was your most recent menstrual period?	☐	☐
42.	How much time do you usually have from the start of one period to the start of another?	☐	☐
43.	How many periods have you had in the last year?	☐	☐
44.	What was the longest time between periods in the last year?	☐	☐

Explain "YES" answers here (list Question #):

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. We understand that this examination is primarily for screening and is not intended to replace routine health care visits by the athlete's personal physician. We know of no reason why the athlete should not participate in supervised athletic activities. We are aware that there is an inherent risk of injury and illness, including brain injury, paralysis and death associated with sports participation. In consideration of acceptance of this examiniation, we waive any and all claims for ourselves and heirs against the physicians associated with this examination, for injury or illness which may directly or indirectly result from the athlete's sports participation. In addition to the routine medical evaluation required by the league, we understand that further evaluation and testing may be recommended and required prior to participation.

Signature of Student   Date   Signature of Parent/Guardian   Date

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Student Name

This section to be filled out by Medical Personnel

Height (inches):	Weight (lbs.):	Pulse (/min):	Blood Pressure:

	Normal	Abnormal Findings:
Appearance:	☐	
Eyes/Ears/Nose/Throat:	☐	
Lymph nodes of neck:	☐	
Heart:	☐	
Lungs:	☐	
Pulses:	☐	
Abdomen:	☐	
Skin:	☐	
Musculoskeletal:		
Neck:	☐	
Back:	☐	
Shoulder/Arm:	☐	
Elbow/Forearm:	☐	
Wrist/Hand:	☐	
Hip/Thigh:	☐	
Knee:	☐	
Leg/Ankle:	☐	
Foot/Toes:	☐	

Other abnormalities:

Assessment:

The student is:

☐ Cleared to participate without restrictions.

☐ Cleared with restrictions:

☐ Not Cleared. Needs further evaluation/rehabilitation for:

☐ Referred to:

☐ Other recommendations/comments:

David M. Bell, MD
Orthopaedic Surgery and Sports Medicine

Date

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