PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _________________________________________________________________ Date of birth: ____________________________

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION

<table>
<thead>
<tr>
<th>Examinations</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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MEDICAL

**Appearance**
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)

**Eyes, ears, nose, and throat**
- Pupils equal
- Hearing

**Lymph nodes**

**Heart**
- Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)

**Abdomen**

**Skin**
- Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis

Neurological

MUSCULOSKELETAL

**Neck**

**Back**

**Shoulder and arm**

**Elbow and forearm**

**Wrist, hand, and fingers**

**Hip and thigh**

**Knee**

**Leg and ankle**

**Foot and toes**

**Functional**
- Double-leg squat test, single-leg squat test, and box drop or step drop test

Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of these.

Name of health care professional (print or type): ______________________________________________________ Date: ___________________

Address: ______________________________________________________________________ Phone: ___________________________

Signature of health care professional: ___________________________________________________________________, MD, DO, NP, or PA