# 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

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<tr>
<th>Height:</th>
<th>Weight:</th>
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| BP: / ( / ) | Pulse: | Vision: R 20/ | L 20/ | Corrected: □ Y □ N |

## 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 those.

Name of health care professional (print or type): ___________________________________________________

Date: ___________________

Address: ________________________________________________________________________

Phone: ___________________________

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