Pre-participation Physical Evaluation
PHYSICAL EXAMINATION FORM

Date of Exam _____

Name _____ Date of birth _____

TO BE COMPLETED BY PHYSICIAN

Consider reviewing questions on cardiovascular symptoms.

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. [b]Consider GU exam if in private setting. Having third party present is recommended. [c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

COVID: Have you tested positive for COVID-19?	Yes_____	No_____
Have you had any known exposure to a COVID-19 positive individual?	Yes_____	No_____
Have you been tested for COVID-19?	Yes_____	No_____
Have you had any new onset of cough or shortness of breath?	Yes_____	No_____
Have you experienced any recent temperature greater than 100.3º	Yes_____	No_____

☐ *Cleared for all sports without restriction*

☐ *Cleared for all sports without restriction with recommendations for further evaluation or treatment for* _____

_____

☐ *Not cleared*

- ☐ *Pending further evaluation*
- ☐ *For any sports*
- ☐ *For certain sports* _____

Reason _____

Recommendations _____

_____

Name of physician (print/type) _____ *Date* _____

Address _____ *Phone* _____

Signature of physician _____ *MD, DO, NP, PA, DC, Spc.*