University at Buffalo
Preparticipation Physical Evaluation

Name (Last, First)_____________________ Date____________ Sport(s)_______________

DOB__________ Height______ Weight______ Pulse______ BP___/___(___/___,___/___)

Vision R 20/___ L 20/___ Corrected: Y N Pupils: Equal______ Unequal______

History

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	□	□
2. Do you have an ongoing medical condition (i.e. diabetes or asthma)?	□	□
3. Are you taking any prescription or non-prescription (over the counter) medicines or pills?	□	□
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	□	□
5. Have you ever passed out or nearly passed out DURING exercise?	□	□
6. Have you ever passed out or nearly passed out AFTER exercise?	□	□
7. Have you ever had discomfort, pain, or pressure, in your chest during exercise?	□	□
8. Does your heart race or skip beats during exercise?	□	□
9. Has your doctor ever told you that you have high blood pressure, high cholesterol, a heart murmur, a heart infection?	□	□
10. Has a doctor ever ordered a test for your heart (i.e. ECG, echocardiogram)?	□	□
11. Has anyone in your family ever died for no apparent reason?	□	□
12. Does anyone in your family have a heart problem?	□	□
13. Has any family member or relative died of heart problems or of sudden death before age 50?	□	□
14. Does anyone on your family have Marfan syndrome?	□	□
15. Have you ever spent the night in a hospital?	□	□
16. Have you ever had surgery?	□	□
17. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	□	□
18. Do you regularly use a brace or assistive device?	□	□
19. Has a doctor ever told you that you have asthma or allergies?	□	□
20. Do you cough wheeze, or have difficulty breathing during or after exercise?	□	□
21. Is there anyone in your family that has asthma?	□	□
22. Have you ever used an inhaler or taken asthma medicine?	□	□
23. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	□	□
24. Have you had infectious mononucleosis (mono) within the last month?	□	□
25. Do you have rashes, pressure sores, or other skin problems?	□	□
26. Have you had a herpes skin infection?	□	□
27. Have you ever had a head injury or concussion? If yes how many?_______	□	□
28. Have you been hit in the head and been confused or lost your memory?	□	□
29. Have you ever had a seizure?	□	□
30. Do you have headaches with exercise?	□	□
31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	□	□
32. Have you ever been unable to move your arms or legs after being hit or falling?	□	□
33. When exercising in the heat, do you have sever muscle cramps or become ill?	□	□
34. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	□	□
35. Have you had any problems with your eyes or vision?	□	□
36. Do you wear protective eyewear, such as goggles or a face shield?	□	□
37. Are you happy with your weight?	□	□
38. Are you trying to gain or lose weight?	□	□
39. Has anyone recommended you change your weight or eating habits?	□	□
40. Do you limit or carefully control what you eat?	□	□
41. Do you have any concerns that you would like to discuss with a doctor?	□	□
Circle below if you:		
42. Have you ever had an injury like a sprain, muscle or ligament tear that caused you to miss a practice or game?	□	□
43. Have you have had any broken or fractured bones or dislocated joints?	□	□
44. Have had a bone or joint injury that required x-ray, MRI, CT, surgery, injection, or physical therapy?	□	□

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

Females Only

	Yes	No
42. Have you ever had a menstrual period?	□	□

43. How old were you when you had your first menstrual period?______
44. How many periods have you had in the last 12 months?______

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Explain all YES answers here:____

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Genitourinary (males only)			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Notes:____

- ☐ **Cleared without restriction**
- ☐ **Cleared, with recommendations for further evaluation or treatment for:**____________________
- ☐ **NOT cleared for** ☐**All sports** ☐**Certain sports:**____________________
  Reason:____

Name of physician (print/type):______________________________ **Date**________________
Address:____ **Phone**________________
Signature of physician____