



Mission San Jose High School

Preparticipation Physical Evaluation

HISTORY _____

DATE OF EXAM _____

Name:	Sex:	Age:	Date of Birth:
Address:		Phone:	
School:	Grade:	Sport (s):	
Personal physician:		Phone:	
Emergency contact Name:		Relationship:	Phone:

Explain "Yes" answers on back of form. Circle questions you don't know the answers to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, orthotics)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you had problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check appropriate box and explain on back of form:</i>		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Have you had a severe viral infection (for example, mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
6. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever been held out of a practice or game for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
			FEMALES ONLY		
			13. Are you experiencing any menstrual cycle abnormalities or cessation of menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>

I hereby state that, to the best of my knowledge, the answers on this form are complete and correct. I understand that this examination is primarily for sports participation screening and is not intended to replace routine health care visits as recommended by the student's personal physician. I know of no reason why the referenced student-athlete should not participate in supervised athletic activities. I authorize any of the doctors, clinics, or hospitals referenced, to furnish a complete transcript of the athlete's medical examination results for the purpose of assessing the athlete's ability to participate in interscholastic or competitive sports. I am aware that there is an inherent risk of injury or illness; including brain injury, paralysis, and death, associated with sports participation. In consideration of acceptance of this examination, I waive any and all claims for myself and my heirs against the physicians, clinics, or hospitals associated with this examination, for injury or illness which may directly or indirectly result from the athlete's sports participation.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Mission San Jose Athletic Department
41717 Palm Ave • Fremont, CA • 94539
510-770-0136 (office) • 510-490-1292 (Fax)

Explain "Yes" answers here: _____

*****Do not write below. Physician use only*****

PHYSICAL EXAMINATION				
Name:		Date of Birth:		
Height:	Weight:	Lbs.	Resting Pulse:	BP: /

	Normal	Abnormal Findings
<u>MEDICAL</u>		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
<u>MUSCULOSKELETAL</u>		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____
- Not cleared. Needs to be examined by: _____ for: _____
- Not cleared for: _____ Reason: _____

Recommendations: _____

Signature of Physician: _____, MD Date: _____