

Minnesota State University, Mankato Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Birthdate _____ SSN# _____
Last First MI

Ht _____ Wt _____ Sport(s) _____ Pulse _____ B/P ____ / ____ (____ / ____ , ____ / ____)

Vision R 20/____ L 20/____ Corrected Yes No Pupils: Equal _____ Unequal _____

Follow-Up Questions on More Sensitive Issues

Yes No

1. Do you feel stressed out or under a lot of pressure? Yes No
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? Yes No
3. Do you feel safe? Yes No
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? Yes No
5. During the past 30 days, did you use chewing tobacco, snuff, or dip? Yes No
6. During the past 30 days, have you had at least 1 drink of alcohol? Yes No
7. Have you ever taken steroid pills or shots without a doctor's prescription? Yes No
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance? Yes No

Notes: _____

	Normal	Abnormal Findings/Notes
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
LABS/TESTS (if appropriate)		
Hgb/Hct		
Ferritin		

Name of Physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of Physician _____, MD or DO

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CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

Cleared without restriction

Cleared, with recommendation for further evaluation or treatment for: _____

Not cleared for: All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

IMMUNIZATIONS (eg, tetanus/diphtheria/pertussis; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

Up to date (see attached documentation) Not up to date Specify _____

Name of Physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of Physician _____, MD or DO

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