CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

# Pre-Participation Sports Physical

**Name:** _____ **Date of Birth:** _____

**Age:** _____ **Grade:** _____ **Gender:** ☐Male ☐Female **School:** _____

List all sports planned this year (even if not sure): _____

List last year's sports, if participated: _____

Any problems/injuries during last year's sports, if participated: _____

_____

Medications: ☐None ☐Yes: _____

Allergies (medications, food, stinging insects): ☐No ☐Yes: _____

If yes, have you ever needed an Epi-Pen injection (either at home or at the ER?): _____

Do you have any history of major medical problems (requiring multiple doctor visits)?

☐ No ☐ Yes: _____

Have you had any medical history of problems with organs such as the eyes, heart, lungs, kidneys, spleen, or testicles?

☐No ☐Yes: _____

Do you have any history of asthma? ☐No ☐Yes

If yes, have you ever used/needed an inhaler? ☐No ☐Yes

Does anyone in your family have asthma? ☐No ☐Yes; who: _____

Do you ever get wheezing, coughing, or shortness of breath with exercise?

☐No ☐Yes: _____

Do you have any history of heart trouble? ☐No ☐Yes: _____

Has anyone in your family had a heart condition or heart attack BEFORE age 50?

☐No ☐Yes: _____

Does anyone in your family have RHYTHM problems with their heart, or have trouble with suddenly passing out?

☐No ☐Yes: _____

-Continue on Back-

Have you ever passed out during or after exercise?

☐No ☐Yes: _____

Do you have pain or pressure in your chest during exercise?

☐No ☐Yes: _____

Have you ever had surgery? ☐No ☐Yes: _____

Have you ever had a seizure? ☐No ☐Yes: _____

Have you ever had a head injury or concussion? ☐No ☐Yes: _____

Do you have headaches with exercise? ☐No ☐Yes: _____

Have you ever fractured a bone in your neck or spine?

☐No ☐Yes: _____

Have you had any injury to a bone or joint that CONTINUES to bother you?

☐No ☐Yes: _____

Has a doctor ever restricted your participation from sports in the past?

☐No ☐Yes: _____

Have you had COVID-19 illness? ☐No ☐Yes

**Females only:** Have you started periods yet? ☐No ☐Yes

If yes, are they regular or irregular? ☐Regular ☐Irregular

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## Provider Section:

Height: _____ Weight: _____ BMI: _____ BP: _____ Pulse: _____

Vision: ☐Corrected ☐Uncorrected R: 20/____ L: 20/____

| | | |
|---|---|---|
| HEENT: | Normal | Abnormal: _____ |
| Lungs: | Normal | Abnormal: _____ |
| Cardiovascular: | Normal | Abnormal: _____ |
| Abdominal: | Normal | Abnormal: _____ |
| Hernia (male): | No | Yes: _____ |
| Cervical spine: | Normal | Abnormal: _____ |
| Upper extremities: | Normal | Abnormal: _____ |
| Thoracic/Lumbar Spine: | Normal | Abnormal: _____ |
| Lower extremities: | Normal | Abnormal: _____ |

Additional notes/comments: _____

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# Pre-Participation Sports Physical

*** Return this section to Athletic Department at School ***

**Name:** _____ **Date of Birth:** _____

Medications: _____

Allergies: _____

☐ Cleared for all sports without restriction.

☐ Cleared for all sports without restriction, with recommendation(s) noted below.

☐ **Not cleared:**

- ☐ For specific sports: _____
- ☐ For all sports.
- ☐ Follow-up plan/reevaluation date: _____

Recommendations/Comments: _____

_____

Physician name: _____

Signature: _____ Date: _____

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