University Health Services
University of Massachusetts Boston
(617) 287-5660

Pre-participation Sports Physical Examination

Name (Last, First,M) _____ Sex: M F Age:_____ Date of Birth:_____

Address:_____ Phone_____

City, State, Zip_____

	Y	N
Have you had a medical illness or injury since your last check up or sport physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or to improve your performance?	☐	☐
Do you have any allergies (i.e. pollen, medicine, food or stinging insects)?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any blood relative (family member and/or grandparent) died of heart problems or sudden death before age 50?	☐	☐
Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month?	☐	☐
Has a health care provider ever denied or restricted your participation in sports for any heart problems?	☐	☐
Do you have any current skin problems (i.e., itching, rashes, acne, warts, fungus or blisters)?	☐	☐
Have you had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐

	Y	N
Have you ever become ill from exercising in the heat?	☐	☐
Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
Do you use any special protective equipment or devices that aren't usually used for your sport or position (i.e. knee braces, special neck roll, foot orthotics, teeth retainers or hearing aids)?	☐	☐
Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts or protective eyewear?	☐	☐
Have you ever had a sprain, strain or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with paid or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, check the appropriate box and explain:

☐**Head**	☐**Elbow**	☐**Hip**
☐**Neck**	☐**Forearm**	☐**Thigh**
☐**Back**	☐**Wrist**	☐**Knee**
☐**Chest**	☐**Hand**	☐**Shin/Calf**
☐**Shoulder**	☐**Finger**	☐**Ankle**
☐**Upper Arm**	☐**Foot**	

	Y	N
Do you want to weigh more or less than you do now?	☐	☐
Do you loose weight regularly to meet the requirements of your sport?	☐	☐
Do you feel stressed out?	☐	☐

Females Only

When was your first period?

When was your most recent menstrual period?

How much time do you usually have from the start of one period to the start of another?

How many periods have you had in the last year?

What was the longest time between periods in the last year?

Explain here why any question was answered "yes".

Name (Last, First, MI)_____
Sex: M F Height _____ Weight _____ Pulse_____ B/P: (L) (R)
Vision: L 20/_____ R 20/ _____ Both 20/ _____ Corrected: Y N Pupils Equal? Y N

Sport of Participation	List Drug Allergies

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance/Emotional Affect		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
EKG REQUIRED (please attach copy)		
Pulses		
Lungs		
Abdomen		
Genitalia (Males only)		
Breasts (Females only)		
Skin		
LAB (Must be completed): UA: Glucose Protein Hct or Hgb:		
Musculoskeletal		
Neck		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Leg/Ankle		
Foot		

CLEARANCE

☐ Medically cleared for sports participation ☐ Cleared after completing evaluation/rehabilitation for:
_____
_____

☐ Not Cleared:

Reason:_____
_____

Recommendations:_____
_____

Health Care Provider Signature _____ Date of Exam: _____
Printed Name:_____ Phone # _____