University of South Carolina
Preparticipation Physical Examination Form

Name: ________________________________ Date of Birth ______ / ______ / ______

Physician Reminders

1. Do you feel stressed on more sensitive issues?
2. Do you ever feel sad, hopeless, depressed, or anxious?
3. Do you feel safe at your home or residence?
4. Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
5. During the last 30 days, did you use chewing tobacco, snuff, or dip?
6. Do you drink alcohol or use any other drugs?
7. Have you ever taken anabolic steroids or used any other performance supplement?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Do you wear a seat belt, use a helmet, and use condoms?

EXAMINATION				
Height	Weight	❑ Male ❑ Female		
BP / (/)	Pulse	Vision Rt. 20 /	Lt . 20/	Corrected ❑ Yes ❑ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency		
Eyes/Ears/Nose/Throat Pupils Equal Hearing		
Lymph Nodes		
Heart [a] Murmurs (auscultation standing, standing, +/- Valsalva Location of point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (Males Only) [b]		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional Duck walk, single leg hop		

Consider reviewing questions on cardiovascular symptoms (History questions 5-14)

[a] Consider ECG, Echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

[b] Consider GU exam if in private setting. Having third party present is recommended.

[c] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

❑ Cleared for all sports without restriction

❑ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____

____

❑ Not Cleared

- ❑ Pending further evaluation
- ❑ For any sports
- ❑ For certain sports

Reason ____ _

Recommendations ____ ______

____ ______

I have examined the above-named athlete and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the athlete and/or parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/type)____ Date ______ / ______ / ______

Address ____ Phone (______) _______ - _________

Signature of Physician ____ MD or DO

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