

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	28. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your heart ever race or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you had a herpes or MRSA skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you get lightheaded or feel more short of breath than expected during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	36. Do you have a history of seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had an unexplained seizure?	<input type="checkbox"/>	<input type="checkbox"/>	37. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you get more tired or short of breath more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	<input type="checkbox"/>	<input type="checkbox"/>	40. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you get frequent muscle cramps when exercising?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>	42. Do you or someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	<input type="checkbox"/>	<input type="checkbox"/>	43. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	<input type="checkbox"/>	47. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	48. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	<input type="checkbox"/>	<input type="checkbox"/>	49. Are you on a special diet or do you avoid certain types of foods?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace, orthotics, or other assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	50. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you have a bone, muscle, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>	51. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do any of your joints become painful, swollen, feel warm, or look red?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?	<input type="checkbox"/>	<input type="checkbox"/>	52. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			53. How old were you when you had your first menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			54. How many periods have you had in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

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

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
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, supine, +/- 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		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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 student 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 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