## ■ PREPARTICIPATION PHYSICAL EVALUATION

# HISTORY FORM

**Complete and sign this form (with your parents if younger than 18) before your appointment. USE BLUE OR BLACK INK.**

**Name:** _____ **Student ID#:** _____

**Sport(s):** _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions {Epi-Pen, inhaler, BCP, etc}, over-the-counter medicines, and supplements (herbal and nutritional).

_____

Do you have any allergies? If yes, please list all your allergies (i.e., medicines, pollens, food, stinging insects).

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)*

| | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| **GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)** | **Yes** | **No** |
|---|---|---|
| 1. Do you have any concerns that you would like to discuss with your provider? | | |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | | |
| 3. Do you have any ongoing medical issues or recent illness? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 4. Have you ever been dizzy, passed out, or nearly passed out during or after exercise? | | |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | |
| 7. Has a doctor ever told you that you have any heart problems or high blood pressure? | | |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | | |

| **HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)** | **Yes** | **No** |
|---|---|---|
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | | |
| 10. Have you ever had a seizure? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? | | |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, Wolff Parkinson White (WPW), or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | | |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | |

| BONE AND JOINT QUESTIONS | Yes | No |
|---|---|---|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | | |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | | |
| a. Do you regularly use a brace, orthotics, or other assistive devices (non-dental)? | | |
| **MEDICAL QUESTIONS** | **Yes** | **No** |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)? | | |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | | |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | | |
| 22. Have you ever become ill while exercising in theheat? | | |
| 23. Do you or does someone in your family have sickle cell trait or disease? | | |
| 24. Have you ever had or do you have any problems with your eyes or vision? | | |

| MEDICAL QUESTIONS (*CONTINUED*) | Yes | No |
|---|---|---|
| 25. Do you worry about your weight? | | |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | | |
| 28. Have you ever had an eating disorder? | | |
| 29. Do you currently have or have you ever had: | | |
| Autoimmune disease/disorder? | | |
| ADD/ADHD? | | |
| IEP? | | |
| 504? | | |
| COVID-19? | | |
| Hearing loss or use hearing aids? | | |
| **FEMALES ONLY (if applicable)** | **Yes** | **No** |
| 30. Have you ever had a menstrual period? | | |
| 31. How old were you when you had your first menstrual period? | | |
| 32. When was your most recent menstrual period? | | |
| 33. How many periods have you had in the past 12 months? | | |

**Explain all "yes" &/or checked answers above; provide month/year.** {Use back of form if necessary.}

_____

_____

_____

_____

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of Student: _____

Signature of Parent/Guardian: _____

Date: _____

**[04/2022]**

# PRE-PARTICIPATION PHYSICAL EVALUATION

Complete using **BLUE** or **BLACK** ink.

(This form is to be completed by the **physician**. Submit **original** to the Athletics Office.)

| Student Name: | | Date of Birth: | | Age: |
|---|---|---|---|---|
| Gender: | | | | |
| SPORT(S): | | | | |
| Height: Weight: | BP: / (sitting, left arm) | Pulse: | BMI % (optional): {Body Mass Index} | Vision: R 20/ L 20/ Corrected ☐ Yes ☐ No |

| **MEDICAL** | Normal | Abnormal Findings/ Recommendations |
|---|---|---|
| Appearance (to include general congenital/ development deformities) | | |
| Eyes/Ears/Nose/Throat (pupils equal, hearing) | | |
| Lymph Nodes | | |
| Heart (murmurs, location of point of maximal impulse) | | |
| Pulses (simultaneous femoral and radial pulses) | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only, to include hernia) - Optional | | |
| Skin (HSV, lesions suggestive of MRSA, tinea corporis) | | |
| Neurologic (including reflexes) | | |
| **MUSCULOSKELETAL / ORTHOPEDIC** | Normal | Abnormal Findings/Recommendations |
| Cervical Spine | | |
| Back (thoracic/lumbar) | | |
| Shoulder/arm | | |
| Elbow/Forearm | | |
| Wrist/Hand/Fingers | | |
| Hip/Thigh | | |
| Knee | | |
| Leg/Ankle | | |
| Foot/Toes | | |
| Functional (duck-walk, single leg hop, front squat) | | |
| Tanner Staging 1 – 5 - Optional | | |

**Patient Education Provided**

- ☐ Stretching emphasized
- ☐ Discussed prevention of sun/heat-related problems
- ☐ Discussed fitness/ ideal weight
- ☐ Discussed treatment of acute injuries
- ☐ Discussed monthly cancer self-exam
- ☐ Vaccination record review

☐ **CLEARED for <u>all sports</u> WITHOUT restriction**. ☐ **Cleared for all sports without restriction with recommendations outlined above in findings/recommendations**

☐ **NOT CLEARED**: ☐ Pending further evaluation ☐ For any sports ☐ For certain sport(s) _____

Needs clearance by specialist: ☐ Orthopedist ☐ Cardiologist ☐ Other _____

Explain _____

**PHYSICIAN'S STATEMENT:**

**(*Student's name)** _____ **was <u>examined by me</u> on (date)** _____ for a pre-participation physical evaluation.

**I have reviewed the attached health history** and the athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. 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.

**Physician's Signature: X** _____ _____

***Do not sign without Examination Date filled in.** Date Physician Signed

_____

**** Print Physician NAME if not on Physician Stamp**

_____

**** Print Physician PHONE if not on Physician Stamp**

**[4/2022]**

**Physician's Stamp Here