

■ 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 <i>Staphylococcus aureus</i> (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 the heat?		
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, fast, 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: _____



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:			Graduating Year:		
SPORT(S):					
Height:	Weight:	BP: / (sitting, left arm)	Pulse:	BMI % (optional): {Body Mass Index}	Vision: R 20/ L 20/ Corrected <input type="checkbox"/> Yes <input type="checkbox"/> 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		

<p>Patient Education Provided</p> <p><input type="checkbox"/> Stretching emphasized</p> <p><input type="checkbox"/> Discussed prevention of sun/heat-related problems</p> <p><input type="checkbox"/> Discussed fitness/ideal weight</p> <p><input type="checkbox"/> Discussed treatment of acute injuries</p> <p><input type="checkbox"/> Discussed monthly cancer self-exam</p> <p><input type="checkbox"/> Vaccination record review</p>
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CLEARED for all sports 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 examined by me 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 _____

**Physician's Stamp Here

** Print Physician NAME if not on Physician Stamp

** Print Physician PHONE if not on Physician Stamp