■ 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.)

ama			Data of hirth					
			Date of birth					
x Age Grade Scho	Grade School Sport(s)							
Medicines and Allergies: Please list all of the prescription and over-	the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking				
Do you have any allergies? \square Yes \square No \square If yes, please iden	ntify spe	ecific all						
☐ Medicines ☐ Pollens			☐ Food ☐ Stinging Insects					
plain "Yes" answers below. Circle questions you don't know the ans	swers t	0.						
ENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No			
Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?					
2. Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?					
below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:			28. Is there anyone in your family who has asthma?					
3. Have you ever spent the night in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?					
4. Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?					
EART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?					
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			32. Do you have any rashes, pressure sores, or other skin problems?					
Have you ever had discomfort, pain, tightness, or pressure in your			33. Have you had a herpes or MRSA skin infection?					
chest during exercise?			34. Have you ever had a head injury or concussion?					
7. Does your heart ever race or skip beats (irregular beats) during exercise?			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?					
8. Has a doctor ever told you that you have any heart problems? If so,			36. Do you have a history of seizure disorder?					
check all that apply: ☐ High blood pressure ☐ A heart murmur			37. Do you have headaches with exercise?					
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?					
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?					
Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat?					
during exercise? 1. Have you ever had an unexplained seizure?			41. Do you get frequent muscle cramps when exercising?					
Do you get more tired or short of breath more quickly than your friends			42. Do you or someone in your family have sickle cell trait or disease? 43. Have you had any problems with your eyes or vision?	-				
during exercise?			44. Have you had any eye injuries?					
EART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?					
3. Has any family member or relative died of heart problems or had an			46. Do you wear protective eyewear, such as goggles or a face shield?					
unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?					
4. Does anyone in your family have hypertrophic cardiomyopathy, Marfan			48. Are you trying to or has anyone recommended that you gain or					
syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic			lose weight?					
polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of foods?					
5. Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder? 51. Do you have any concerns that you would like to discuss with a doctor?					
implanted defibrillator?			FEMALES ONLY					
6. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			52. Have you ever had a menstrual period?					
ONE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period?					
7. Have you ever had an injury to a bone, muscle, ligament, or tendon			54. How many periods have you had in the last 12 months?					
that caused you to miss a practice or a game?			Explain "yes" answers here					
Have you ever had any broken or fractured bones or dislocated joints?								
9 Have you ever had an injury that required y-rave MRI CT econ								
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		1						
injections, therapy, a brace, a cast, or crutches? D. Have you ever had a stress fracture? Have you ever been told that you have or have you had an x-ray for neck								
injections, therapy, a brace, a cast, or crutches? 0. Have you ever had a stress fracture? 1. 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)								
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■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name Date of birth ___ **PHYSICIAN REMINDERS** 1. 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?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).													
EXAMINATION													
Height		Weigl	ht	□ Mal	e	☐ Female							
BP /	(/)		Pulse Visio	n R	20/	L 20/ Co	rrected D Y D N					
MEDICAL	,	,				NORMAL	ABNORI	WAL FINDINGS					
Appearance • Marfan stigmata (kyph arm span > height, hyp				e, pectus excavatum, arachnodactyly, insufficiency)									
Eyes/ears/nose/throat Pupils equal Hearing													
Lymph nodes					1								
Heart a • Murmurs (auscultation • Location of point of ma			alsalva	a)									
Pulses • Simultaneous femoral	and radial pul	ses											
Lungs					\Box								
Abdomen													
Genitourinary (males only)	b												
Skin HSV, lesions suggestive	e of MRSA, tin	ea corpori	is										
Neurologic ^c													
MUSCULOSKELETAL													
Neck					\Box								
Back					_								
Shoulder/arm					_								
Elbow/forearm					_								
Wrist/hand/fingers					4								
Hip/thigh					4								
Knee					4								
Leg/ankle					\dashv								
Foot/toes					_								
Functional Duck-walk, single leg l	пор												
☐ Cleared for all sports w	setting. Having t or baseline neuro ithout restricti	third party p opsychiatric	resent testing		mer	nt for							
□ Not cleared													
☐ Pending f	urther evaluat	tion											
☐ For any s	ports												
☐ For certai													
	п эрогьэ												
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/ty	pe)							Date					
Address							Ph	one					
Signature of physician								, MD or DO					
- , ,													