PRE-PARTICIPATION 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 history form in the chart. Should the physician have their own form, please use that form in lieu of this one.)

LAST NAME | FIRST NAME | MI | DATE OF EXAM

GENDER | DATE OF BIRTH | AGE | GRADE

MEDICINES AND ALLERGIES:

Please list all 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: Medicines Pollens Food Stinging Insects

_____

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

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ____Asthma ____Anemia ____Diabetes ____Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. . Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ___High blood pressure ___A heart murmur ___High cholesterol ___A heart infection ___Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. DO YOU GET MORE TIRED OR SHORT OF BREATH MORE QUICKLY THAN YOUR FRIENDS DURING EXERCISE?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
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)?		
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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		

PRE-PARTICIPATION PHYSICAL EVALUATION - HISTORY FORM (cont.)

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

BONE AND JOINT QUESTIONS	YES	NO
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
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)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	**YES**	**NO**
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
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?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**YES**	**NO**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

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 _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Rev.8/06/2023

PRE-PARTICIPATION PHYSICAL EVALUATION - HISTORY FORM

(FOR ATHLETE WITH SPECIAL NEEDS)

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. This document is only necessary when the individual has a documented special need. The physician should keep this history form in the chart.)

LAST NAME FIRST NAME MI DATE OF EXAM

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	YES	NO
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		
Explain "yes" answers on back of form.		
PLEASE INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING.	YES	NO
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		
Explain "yes" answers on back of form.		

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

SIGNATURE OF ATHLETE DATE

SIGNATURE OF PARENT/GUARDIAN DATE

PRE-PARTICIPATION PHYSICAL EVALUATION - PHYSICAL EXAMINATION FORM

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

LAST NAME FIRST NAME MI DATE OF EXAM

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).

HEIGHT		WEIGHT					GENDER	Male	Female
BP PULSE	/	(/)	VISION	R 20/	L 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 - CONSIDER ECG, ECHOCARDIOGRAM, AND REFERRAL TO CARDIOLOGY FOR ABNORMAL CARDIAC HISTORY OR EXAM.									
• MURMURS (AUSCULTATION STANDING, SUPINE, +/- VALSALVA)									
• LOCATION OF POINT OF MAXIMAL IMPULSE (PMI)									
PULSES - SIMULTANEOUS FEMORAL AND RADIAL PULSES									
LUNGS									
ABDOMEN									
GENITOURINARY (MALES ONLY)									
CONSIDER GU EXAM IF IN PRIVATE SETTING. HAVING THIRD PARTY PRESENT IS RECOMMENDED.									
SKIN - HSV, LESIONS SUGGESTIVE OF MRSA, TINEA CORPORIS									
NEUROLOGIC									
CONSIDER COGNITIVE EVALUATION OR BASELINE NEUROPSYCHIATRIC TESTING IF A HISTORY OF SIGNIFICANT CONCUSSION.									
NECK									
BACK									
SHOULDER/ARM									
ELBOW/FOREARM									
WRIST/HAND/FINGERS									
HIP/THIGH									
KNEE									
LEG/ANKLE									
FOOT/TOES									
FUNCTIONAL - DUCK-WALK, SINGLE LEG HOP									

_____ CLEARED FOR ALL SPORTS WITHOUT RESTRICTION _____ CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS

_____ NOT CLEARED _____ PENDING FURTHER EVALUATION _____ FOR ANY SPORTS _____ FOR CERTAIN SPORTS _____

REASON: _____

RECOMMENDATIONS: _____

I have examined the above-named student and completed the pre-participation 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

Rev.8/06/2023

PHYSICAL EVALUATION CLEARANCE FORM (REQUIRED TO BE IN ATHLETE FILE)

LAST NAME	FIRST NAME	MI	DATE OF EXAM
GENDER	DATE OF BIRTH	AGE	GRADE

_____ CLEARED FOR ALL SPORTS WITHOUT RESTRICTION _____ CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS

_____ NOT CLEARED _____ PENDING FURTHER EVALUATION _____ FOR ANY SPORTS _____ FOR CERTAIN SPORTS _____

REASON: _____

RECOMMENDATIONS: _____

I have examined the above-named student and completed the pre-participation 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	

EMERGENCY INFORMATION

Allergies

_____

_____

_____

_____

Other information

_____

_____

_____

_____

_____