## 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 A	ge Grade	School		Sport(s)
Medicines and A	<b>\llergies:</b> Please list all of t	he prescription and over-the-cou	nter medicines and su	upplements (herbal and nutritional) that you are currently taking
Do you have any Do Medicines		No If yes, please identify spec Pollens	cific allergy below.	□ 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?			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			28. Is there anyone in your family who has asthma?		
Other: 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?		
HEART 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			32. Do you have any rashes, pressure sores, or other skin problems?		
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?		
6. Have you ever had discomfort, pain, tightness, or pressure in your 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     Kawasaki disease     Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
<ol> <li>Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)</li> </ol>			39. Have you ever been unable to move your arms or legs after being hit or falling?		
10. 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?			41. Do you get frequent muscle cramps when exercising?		
11. Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?		
12. Do you get more tired or short of breath more quickly than your friends			43. Have you had any problems with your eyes or vision?		
during exercise?			44. Have you had any eye injuries?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?		
<ol> <li>Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including</li> </ol>			46. Do you wear protective eyewear, such as goggles or a face shield?		
drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		
<ol> <li>Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT</li> </ol>			48. Are you trying to or has anyone recommended that you gain or lose weight?		
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of foods?		
15. Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?		
implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
seizures, or near drowning?			52. Have you ever had a menstrual period?		
BONE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			54. How many periods have you had in the last 12 months?		
18. Have you ever had any broken or fractured bones or dislocated joints?			Explain "yes" answers here		
<ol> <li>Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</li> </ol>					
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?					

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

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment. HE0503

# PREPARTICPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

#### Name

## **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).

EXAMIN	IATION										
Height				Weight			□ Male	□ Female			
BP	/	(	/	)	Pu	lse	Vision	R 20/		L 20/	Corrected 🗆 Y 🗆 N
MEDICA	\L							NOR	MAL		ABNORMAL FINDINGS
							vatum, arachnodactyly,				
Eyes/ear • Pupils • Heari											
Lymph n	iodes										
	nurs (auscultati tion of point of				salva)						
Pulses • Simu	ltaneous femor	al and radial	l pulses								
Lungs											
Abdome	n										
Genitour	inary (males or	וy) <sup>⊳</sup>									
Skin • HSV,	lesions sugges	tive of MRSA	, tinea (	corporis							
Neurolog	,,										
	LOSKELETAL										
Neck											
Back											
Shoulder											
Elbow/fo											
Wrist/ha	nd/fingers										
Hip/thigh	1 I										
Knee											
Leg/ank	le										
Foot/toe	S										
Function	ial -walk single le	a hon									

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

\*Consider GU exam if in private setting. Having third party present is recommended. \*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

□ Cleared for all sports without restriction

Cleared for a	Il sports without restriction with recommendations for further evaluation or treatment for
□ Not cleared	
	Pending further evaluation
	For any sports
	For certain sports
	Reason
Recommendatio	ns

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

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment. HE0503

Date of birth \_