

Pre-Participation Physical Exam: Health History Form

Name: _____ DOB: _____ Grad Yr _____ CHS SHHS

Please check one:

I have checked the allergies and/or medications listed for this student on the Parent Portal and they are current and accurate.

I will confirm the allergies and/or medication listed for this student before the August 1st deadline.

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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH	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 (i.e. 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?		
FAMILY HEART HEALTH	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?		
BONE & JOINT HEALTH		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or 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 devices?		
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 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 _____ Signature of parent/guardian _____

Pre-Participation Physical Exam: Physical Examination Form

Name: _____ DOB: _____ Date of Exam: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
 - a. Do you feel stressed out or under a lot of pressure?
 - b. Do you ever feel sad, hopeless, depressed, or anxious?
 - c. Do you feel safe at your home or residence?
 - d. Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - e. During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - f. Do you drink alcohol or use any other drugs?
 - g. Have you ever taken anabolic steroids or used any other performance supplement?
 - h. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - i. Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (question 5-14).

EXAMINATION:	Height	Weight	Male	Female
BP /	Pulse	Vision R: 20/	L: 20/	Corrected: Y N
MEDICAL		NORMAL		
APPEARANCE		ABNORMAL FINDINGS		
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 				
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 				
Lymph nodes				
Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 				
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 				
Lungs				
Abdomen				
Genitourinary (males only)*				
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 				
Neurologic*				
MUSCULOSKELETAL				
Neck				
Back				
Shoulder/arm				
Elbow/forearm				
Wrist/hand/fingers				
Hip/thigh				
Knee				
Leg/ankle				
Foot/toes				
Functional <ul style="list-style-type: none"> Duck-walk, single leg h 				

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
 *Consider GU exam if in a private setting. Having a 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 all sports without restriction with recommendations for further evaluation or treatment for _____
 Not cleared
 Pending further evaluation
 For any sports
 For certain sports
 Reason _____
 Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contradictions 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 potential consequences are completely explained to the athlete (and parents/guardians). STAMP:

Name of physician _____ Signature of physician _____
 Address: _____

***C&SH ATHLETES, please submit a photocopy of the back and front of the insurance card with this form.** Thank you! - Athletics Department