

# ■ PREPARTICIPATION PHYSICAL EVALUATION



## HISTORY FORM pg. 1 – to be signed by the parent or legal custodian

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex: M/F \_\_\_\_\_

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, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, 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? (check box next to appropriate number)

|                                             | Not at all                 | Several days               | Over half the days         | Nearly every day           |
|---------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Feeling nervous, anxious, or on edge        | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Not being able to stop or control worrying  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Little interest or pleasure in doing things | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Feeling down, depressed, or hopeless        | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS<br>(Explain "Yes" answers at the end of this form.<br>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?                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has a provider ever denied or restricted your participation in sports for any reason?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any ongoing medical issues or recent illness?                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART HEALTH QUESTIONS ABOUT YOU                                                                                        | Yes                      | No                       |
| 4. Have you ever passed out or nearly passed out during or after exercise?                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has a doctor ever told you that you have any heart problems?                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.       | <input type="checkbox"/> | <input type="checkbox"/> |

| HEART HEALTH QUESTIONS ABOUT YOU<br>(CONTINUED)                                                                                                                                                                                                                                                                       | Yes                      | No                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise?                                                                                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had a seizure?                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)?                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 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, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |

## HISTORY FORM pg. 2 – to be signed by the parent or legal custodian

| 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?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you?                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| MEDICAL QUESTIONS                                                                                                                                     | Yes                      | No                       |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever become ill while exercising in the heat?                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you or does someone in your family have sickle cell trait or disease?                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever had or do you have any problems with your eyes or vision?                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |

| MEDICAL QUESTIONS (CONTINUED)                                                        | Yes                      | No                       |
|--------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 25. Do you worry about your weight?                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are you trying to or has anyone recommended that you gain or lose weight?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you ever had an eating disorder?                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| FEMALES ONLY                                                                         | Yes                      | No                       |
| 29. Have you ever had a menstrual period?                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. How old were you when you had your first menstrual period?                       |                          |                          |
| 31. When was your most recent menstrual period?                                      |                          |                          |
| 32. How many periods have you had in the past 12 months?                             |                          |                          |

Explain "Yes" answers here.

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

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

# PHYSICAL EXAMINATION FORM –signed and dated by the LMP who performed the examination

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### PHYSICIAN REMINDERS

- 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, e-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-enhancing 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

| EXAMINATION                                                                                                                                                                                                                     |                          |                     |                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------|------------------------------------------------------------------|
| Height:                                                                                                                                                                                                                         | Weight:                  |                     |                                                                  |
| BP: / ( / )                                                                                                                                                                                                                     | Pulse:                   | Vision: R 20/ L 20/ | Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL                                                                                                                                                                                                                         | NORMAL                   | ABNORMAL FINDINGS   |                                                                  |
| Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul> | <input type="checkbox"/> |                     |                                                                  |
| Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>                                                                                                                    | <input type="checkbox"/> |                     |                                                                  |
| Lymph nodes                                                                                                                                                                                                                     | <input type="checkbox"/> |                     |                                                                  |
| Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>                                                                              | <input type="checkbox"/> |                     |                                                                  |
| Lungs                                                                                                                                                                                                                           | <input type="checkbox"/> |                     |                                                                  |
| Abdomen                                                                                                                                                                                                                         | <input type="checkbox"/> |                     |                                                                  |
| Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>                                           | <input type="checkbox"/> |                     |                                                                  |
| Neurological                                                                                                                                                                                                                    | <input type="checkbox"/> |                     |                                                                  |
| MUSCULOSKELETAL                                                                                                                                                                                                                 | NORMAL                   | ABNORMAL FINDINGS   |                                                                  |
| Neck                                                                                                                                                                                                                            | <input type="checkbox"/> |                     |                                                                  |
| Back                                                                                                                                                                                                                            | <input type="checkbox"/> |                     |                                                                  |
| Shoulder and arm                                                                                                                                                                                                                | <input type="checkbox"/> |                     |                                                                  |
| Elbow and forearm                                                                                                                                                                                                               | <input type="checkbox"/> |                     |                                                                  |
| Wrist, hand, and fingers                                                                                                                                                                                                        | <input type="checkbox"/> |                     |                                                                  |
| Hip and thigh                                                                                                                                                                                                                   | <input type="checkbox"/> |                     |                                                                  |
| Knee                                                                                                                                                                                                                            | <input type="checkbox"/> |                     |                                                                  |
| Leg and ankle                                                                                                                                                                                                                   | <input type="checkbox"/> |                     |                                                                  |
| Foot and toes                                                                                                                                                                                                                   | <input type="checkbox"/> |                     |                                                                  |
| Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>                                                                                       | <input type="checkbox"/> |                     |                                                                  |

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

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# MEDICAL ELIGIBILITY FORM – to be signed and dated by the LMP

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

\_\_\_\_\_

☐ Medically eligible for certain sports

\_\_\_\_\_

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: \_\_\_\_\_

\_\_\_\_\_

I have examined the student named on this form and completed the pre-participation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

## SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_

Emergency contacts: \_\_\_\_\_

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