



This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations.

■ PREPARTICIPATION PHYSICAL EVALUATION

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Note: Complete and sign this form (with your parents il Name:	-		pointment. te of birth:	
Date of examination:				
Sex assigned at birth (F, M, or intersex):	How do	you identify your (gender? (F, M, or other)	:
List past and current medical conditions.				
Have you ever had surgery? If yes, list all past surgical				
Medicines and supplements: List all current prescription	ons, over-the-co	unter medicines, a	nd supplements (herbal	and nutritional).
Do you have any allergies? If yes, please list all your	allergies (ie, me	dicines, pollens, fo	ood, stinging insects).	
Patient Health Questionnaire Version 4 (PHQ-4) Over any of the following problems? (Check response.)	r the last 2 week	s, how often have	you been bothered by	
	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0⊙	10	20	3 O
Not being able to stop or control worrying	0 💿	10	20	3 O
Little interest or pleasure in doing things	00	10	20	3 🔘
Feeling down, depressed, or hopeless	00	10	20	3 🔘
(A sum of ≥ 3 is considered positive on either su	bscale [question	is 1 and 2, or que	stions 3 and 4] for scre	ening purposes.)

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

	RT HEALTH QUESTIONS ABOUT YOU NTINUED)	Yes	No
9.	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10.	Have you ever had a seizure?		
HEA	RT 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)?		
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)?		
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		



Date: ___



	NE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED)	Yes	
4.	Have you ever had a stress fracture or an injury			25. Do you worry about your weight?		brack
	to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			26. Are you trying to or has anyone recommended that you gain or lose weight?		
5.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?		1
MEI	DICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		1
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMALES ONLY	Yes	
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			29. Have you ever had a menstrual period?30. How old were you when you had your first menstrual period?		_
18.	Do you have groin or testicle pain or a painful			31. When was your most recent menstrual period?	+	_
19.	bulge or hernia in the groin area? Do you have any recurring skin rashes or			32. How many periods have you had in the past 12		_
	rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			months? Explain "Yes" answers here.		_
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?					_
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?					_
22.	Have you ever become ill while exercising in the heat?					_
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23.	Do you or does someone in your family have sickle cell trait or disease?		1			

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