

Preparticipation Physical Evaluation HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician.)

Date of Exam: _____

Student ID: _____

Last Name: _____ First Name: _____

Birthdate: _____

Age: _____ Sex: _____ Grad Year: _____ School: _____ Student ID# _____

Sports: _____

Medication you are currently taking (prescription and Over the counter):

Do you currently have any allergies? (if yes, list them below):

Fall Sport: _____

Winter Sport: _____

Spring Sport: _____

GENERAL QUESTIONS		Yes	No	MEDICAL QUESTIONS (CONT.)		Yes	No
01. Have you ever been denied or restricted participation in sports for any reason? (explain)				39. Have you ever been unable to move your arms or legs after being hit or falling?			
02. Do you have any ongoing medical conditions? (diabetes, Asthma, Anemia, etc.)				40. Have you ever become ill while exercising in the heat?			
03. Have you ever been admitted and spend the night in the hospital?				41. Do you get frequent muscle cramps when exercising?			
04. Have you ever had surgery?				42. Do you or someone in your family have sickle cell trait or disease?			
HEART HEALTH QUESTIONS ABOUT YOU				43. Have you had any problems with your eyes or vision?			
05. Have you ever passed out, or nearly passed out DURING or AFTER exercise?				44. Have you had any eye injuries?			
06. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				45. Do you wear glasses or contact lenses?			
07. Does your heart ever race or skip beats (irregular heartbeats) during exercise?				46. Do you wear protective eyewear, such as goggles or a face shield?			
08. Has a doctor told you have any heart problems?				47. Do you worry about your weight?			
09. Has your doctor ever ordered a test for your heart? (ECG, EKG, echocardiogram)				48. Are you trying to gain or lose weight?			
10. Do you get lightheaded or feel shortness of breath when exercising?				48a. Has anyone recommended that you try to gain or lose weight?			
11. Have you ever had an unexplained seizure?				49. Are you on a special diet or do you avoid certain types of foods?			
12. Do you get more tired or short of breath more quickly than your friends during exercise?				50. Have you ever had an eating disorder?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY				51. Do you have any concerns that you would like to discuss with your doctor?			
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?				FEMALES ONLY			
14. Does anyone in your family have heart conditions? (hypertrophic cardiomyopathy, marfan syndrome, long QT syndrome, etc.)				52. Have you ever had a menstrual period?			
15. Does anyone in your family have a pacemaker, or implanted defibrillator?				53. How old were you when you had your 1st menstrual period?			
16. Has anyone in your family had unexplained fainting, seizures or near drowning?				54. How many periods have you had in the last 12 months?			
BONE AND JOINT QUESTIONS				MENTAL HEALTH QUESTIONS			
17. Have you had an injury to muscle, tendon, bone, or ligament that caused you to miss a practice or game?				55. Have you ever sought the advice of a mental health care provider?			
18. Have you ever broken or fractured bones or dislocated joints?				56. Do you often have trouble sleeping?			
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				57. Do you often feel like you lack energy?			
20. Have you ever had a stress fracture?				58. Do you often think about things over and over?			
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?				59. Do you tend to blame yourself for everything bad that happens?			
22. Do you regularly use a brace, orthotics, or other assistive device?				60. Do you feel moody or irritable if you miss an exercise session?			
23. Do you have a bone, muscle, or joint injury that bothers you?				61. Do you feel anxious or nervous most of the time?			
24. Do any of your joints become painful, swollen, feel warm, or look red?				62. Do you often feel sad or depressed?			
25. Do you have any history of juvenile arthritis or connective tissue disease?				63. Do you ever feel hopeless about the future?			
MEDICAL QUESTIONS				64. Do you ever have a hard time managing your emotions? (frustration, anger, impatience)			
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?				65. Do you ever have feelings of hurting yourself or others?			
27. Have you ever been diagnosed with asthma?				66. Have you ever had suicidal thoughts?			
28. Have you ever used an inhaler or taken asthma medicine?				67. Have you ever made yourself sick because you were uncomfortably full?			
29. Is there anyone in your family who has asthma?				68. Do you ever feel as though you have lost control over how much you eat?			
30. Do you have groin pain or a painful bulge or hernia in the groin area?				69. Have you recently lost more than 15 pounds in one month?			
31. Have you had infectious mononucleosis (mono) within the last month?				70. Have you ever considered exercise to be the most important thing in your life?			
32. Do you have any rashes, pressure sores, or other skin problems?				71. FEMALES ONLY: Have you had a missed or absent menstrual cycle?			
33. Have you had a herpes or MRSA skin infection?				Please Explain YES answers below with corresponding number (E.g. 11. Seizures at the age of five years old). Attach additional pages if necessary. _____ _____ _____ _____ _____ _____			
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?							

Insurance Name and Number: _____

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: _____

Preparticipation Physical Evaluation

Date of Exam: _____

PHYSICAL EXAMINATION FORM

Last Name: _____

First Name: _____

Birthdate: _____

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)

EXAMINATION		
Height: _____	Weight: _____	☐ Male ☐ Female
BP: _____ / _____	Pulse: _____	Vision: Right Eye 20/____ Left Eye 20/____ Corrected ☐ Yes ☐ No Type of correction: _____
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 ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses (Simultaneous femoral and radial pulses)		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder / Arm		
Elbow / Forearm		
Wrist / Hand / Fingers		
Hip / Thigh		
Knee		
Leg / Ankle		
Foot / Toes		
Functional (i.e. Duck Walk, Single Leg Hop)		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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 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 Supervising Physician: _____ MD or DO Date: _____

Name of Clinician Performing Exam: _____

Signature of Clinician Performing Exam: _____

Physician Group /
Supervising Physician Stamp