PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

KAISER PERMANENTE®

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 assigned at birth (F, M, or inter-sex): _____ **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 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 allergies (i.e. Medicine, pollen, food, stinging insects, etc.)

COVID Vaccine Status: Previously received COVID-19 Vaccine: ☐ Yes ☐ No

If yes, ☐ First Dose ☐ Second Dose

COVID Exposure: Have you tested positive for COVID within the last 3 months: ☐ Yes ☐ No

If Yes, When: _____

If Yes, Did you have symptoms that lasted for 4 days or more? ☐ Yes ☐ No

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Select all that apply)

	Not at all	Several Days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge:	☐ 0	☐ 1	☐ 2	☐ 3
Not being able to stop or control worrying:	☐ 0	☐ 1	☐ 2	☐ 3
Little interest or pleasure in doing things:	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless:	☐ 0	☐ 1	☐ 2	☐ 3

A sum of ≥3 is considered positive on either sub-scale [questions 1 and 2, or questions 3 and 4] for screening purposes

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. 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?	☐	☐
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?	☐	☐

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 practice or game?	☐	☐
15. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐

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HEART 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, ECG or EKG?	☐	☐
9. Do you get light headed or feel shorter breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
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 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 poly- morphic ventricular tachycardia (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐

Explain Yes Answers Here

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?	☐	☐
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA	☐	☐
20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?	☐	☐
21. Have you ever had numbness, tingling, 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?	☐	☐
23. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
24. Have you ever had or do you have any problems with your eyes or vision?	☐	☐
25. Do you worry about your weight?	☐	☐
26. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
27. Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
28. Have you ever had an eating disorder?	☐	☐
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period	☐	☐
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?	☐	

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: _____ Date: _____

Signature of parent or guardian: _____ Date: _____