This form should be placed into the individual's medical file and should *only* be shared with other health care professionals.
The Medical Eligibility Form is the only form that should be submitted to nonmedical personnel at a school or sports organization.

PREPARTICIPATION EVALUATION

HISTORY FORM

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

Name: _____ Date of birth: _____ Date of examination: _____

Sports and Activities: _____

List past and current medical conditions (including mental health disorders such as ADHD, anxiety, depression).

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, vitamins, and supplements (herbal and nutritional).

_____

Do you have any allergies? If yes, please list all your allergies (eg, medicines, pollens, food, stinging insects).

_____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, nonbinary, or another gender): _____

Patient Health Questionnaire Version 4 (PHQ-4)
Over the past 2 weeks, how often have you been bothered by any of the following problems? (Circle response)

	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

Over the past 2 weeks, have you had thoughts that you would be better off dead or hurting yourself in some way? (Circle response)

Not at all	Several days	Over half the days	Nearly every day
0	1	2	3

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. Have you had any recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever had pain, discomfort, or shortness of breath in your chest during exercise?		
5. Have you ever passed out or nearly passed out during or after exercise, or in response to sudden loud noises?		
6. Has a doctor ever told you that you have any heart problem, heart murmur, or high blood pressure?		
7. Has a doctor ever ordered a test for your heart (for example, electrocardiography [ECG/EKG] or echocardiography [ECHO])?		
8. Has a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
9. Has any family member or relative died or had a disability from heart problems before age 50 or had an unexpected or sudden unexplained death (SUD) before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			
10. Does anyone in your family have hypertrophic cardiomyopathy (HCM), dilated cardiomyopathy, Marfan syndrome, arrhythmogenic cardiomyopathy (ACM), long QT syndrome (LQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT) or have a pacemaker or an implanted defibrillator?			

BONE AND JOINT QUESTIONS	Yes	No
11. Have you ever had a fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
12. Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
13. Have you ever had a hit or blow that caused confusion, prolonged headache, or memory problems or been diagnosed with a concussion?		
14. Have you ever had numbness, tingling, or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
15. Are you missing a kidney, an eye, a testicle, spleen, or any other organ? Are any of these organs not functioning properly?		
16. Have you ever become ill while exercising in the heat?		
17. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
18. Have you ever had or do you have any problems with your eyes or vision?		
19. Do you cough, wheeze, or have difficulty breathing during or after physical activity?		
20. Do you have groin or testicular pain or a bulge or lump in the groin area?		
21. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
22. Are you happy with your current weight?		
23. Do you feel pressured to lose or gain weight?		
24. Do you follow a specific diet plan?		
25. Has anyone ever touched you in a way or pressured you to engage in any physical or sexual acts that made you uncomfortable?		
MENSTRUAL QUESTIONS		
26. How old were you when you had your first menstrual period?		
27. When was your most recent menstrual period?		
28. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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: _____

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