This form should be placed into the individual's medical file and should *only* be shared with other health care professionals.

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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).

_____

Biological Sex (F, M): _____

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. Have you ever had 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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Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

PREPARTICIPATION EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

Biological Sex: Male ____ Female ____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues.**
   - Do you feel stressed out or under a lot of pressure?
   - Do you have enough food at home?
   - Do you ever worry about becoming homeless?
   - Do you feel safe at your home/residence, in your neighborhood, at school, and in sports/activities?
   - 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?
   - Do you wear a seat belt, use a helmet, and use condoms?
   - 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?

EXAMINATION			
Height:	Weight:		
BP: /	Pulse:	Vision: R 20/ L 20/	Corrected: ☐ Y ☐ N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia)		
Eyes, ears, nose, and throat		
Lymph nodes		
Cardiovascular • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) • Pulses (radial and femoral)		
Lungs		
Abdomen • Mass or enlarged liver/spleen • CVA tenderness		
Skin • Herpes simplex virus (HSV), *Staphylococcus aureus*, or tinea corporis		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Consider single-leg squat test and/or box drop test		

Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history and/or examination findings.

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

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, ARNP, PA, or ND

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PREPARTICIPATION EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

Biological Sex: Male _____ Female _____

SHARED EMERGENCY INFORMATION

Medical Conditions (Check all that apply)

☐ Anaphylaxis ☐ Asthma ☐ Cardiac Condition ☐ Concussion History ☐ Diabetes ☐ Heat Stroke/ Rhabdomyolysis

☐ Missing Organ ☐ POTS ☐ Seizures ☐ Sickle Cell Disease ☐ Sickle Cell Trait ☐ Stinger History

☐ Other (Specify): _____

_____

☐ Known triggers for conditions listed above (eg, exercise, weather): _____

_____

☐ Environmental & Food Allergies: _____

_____

Condition-Specific Activity Guidelines

☐ Emergency Medications (eg, inhaler, EpiPen): _____

☐ Medications used before, during, or after activity (eg, inhaler before exercise, insulin): _____

_____

☐ Activity Modifications (eg, limit exertion, monitor symptoms, extra hydration breaks): _____

_____

☐ Other: _____

For Evaluating Health Care Professional

☐ Medically eligible for all sports and activities without restriction

☐ Medically eligible for all sports and activities without restriction, with recommendations for further evaluation or treatment of: _____

_____

☐ Medically eligible **AFTER** evaluation and clearance for: _____

_____

☐ Medically eligible for certain sports and activities (list the specific sports or type of sports): _____

_____

☐ Not medically eligible for any sports or activities

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation 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, ARNP, PA or ND

Legal Guardian Acknowledgment to Share With Individual's School or Sports Organizations

☐ I acknowledge that this form may contain protected medical information and authorize its sharing with the participant's school, coaches, and relevant personnel.

Legal guardian name (print or type): _____

Signature of legal guardian: _____ Date: _____

Emergency contacts: _____

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