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:

Fall Sport: _____________________

Winter Sport: __________________

Spring Sport: __________________

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

____

____

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

____

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GENERAL QUESTIONS	Yes	No
01. Have you ever been denied or restricted participation in sports for any reason? (explain)		
02.Do you have any ongoing medical conditions? (diabetes, Asthma, Anemia, etc.)		
03. Have you ever been admitted and spend the night in the hospital?		
04. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		
05. Have you ever passed out, or nearly passed out DURING or AFTER exercise?		
06. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
07. Does your heart ever race or skip beats (irregular heartbeats) during exercise?		
08. Has a doctor told you have any heart problems?		
09. Has your doctor ever ordered a test for your heart? (ECG, EKG, echocardiogram)		
10. Do you get lightheaded or feel shortness of breath when exercising?		
11. have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?		
14. Does anyone in your family have heart conditions? (hypertrophic cardiomyopathy, marfan syndrome, long QT syndrome, etc.)		
15. Does anyone in your family have a pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, seizures or near drowning?		
BONE AND JOINT QUESTIONS		
17. Have you had an injury to muscle, tendon, bone, or ligament that caused you to miss a practice or game?		
18. Have you ever broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS		
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever been diagnosed with asthma?		
28. Have you ever used an inhaler or taken asthma medicine?		
29. Is there anyone in your family who has asthma?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
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?		

MEDICAL QUESTIONS (CONT.)	Yes	No
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to gain or lose weight?		
48a. Has anyone recommended that you try to gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with your doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your 1st menstrual period?		
54. How many periods have you had in the last 12 months?		
MENTAL HEALTH QUESTIONS		
55. Have you ever sought the advice of a mental health care provider?		
56. Do you often have trouble sleeping?		
57. Do you often feel like you lack energy?		
58. Do you often think about things over and over?		
59. Do you tend to blame yourself for everything bad that happens?		
60. Do you feel moody or irritable if you miss an exercise session?		
61. Do you feel anxious or nervous most of the time?		
62. Do you often feel sad or depressed?		
63. Do you ever feel hopeless about the future?		
64. Do you ever have a hard me managing your emotions? (frustration, anger, impatience)		
65. Do you ever have feelings of hurting yourself or others?		
66. Have you ever had suicidal thoughts?		
67. Have you ever made yourself sick because you were uncomfortably full?		
68. Do you ever feel as though you have lost control over how much you eat?		
69. Have you recently lost more than 15 pounds in one month?		
70. Have you ever considered exercise to be the most important thing in your life?		
71. FEMALES ONLY: Have you had a missed or absent menstrual cycle?		

Please Explain YES answers below with corresponding number (E.g. 11. Seizures at the age of five years old). Attach additional pages if necessary.

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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)		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider 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).

Physician Group / Supervising Physician Stamp

Name of Supervising Physician: ______________________________ MD or DO **Date:** __________

Name of Clinician Performing Exam: ______________________________

Signature of Clinician Performing Exam: ______________________________