

# Preparticipation Physical Evaluation History Form

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart)

Date of Exam: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_ Sport(s): \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies?  Yes  No If yes, please identify specific allergy below

Medicines  Pollens  Food  Stinging insects

**Explain "Yes" answers below. Circle questions you don't know the answer to.**

GENERAL QUESTIONS	YES	NO	MEDICAL QUESTIONS	YES	NO	
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other: _____			27. Have you ever used an inhaler or taken asthma medicine?			
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?			
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, your a testicle (males), or any other organ?			
HEART HEALTH QUESTIONS ABOUT YOU			YES	NO		
5. Have you ever passed out or nearly passed out DURING or AFT AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?			
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?			
8. Has a doctor ever told you that you have any heart problems? check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infections <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other: _____			34. Have you ever had a head injury or concussion?			
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?			
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?			
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your after being hit or falling?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			YES	NO		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age of 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			39. Have you ever been unable to move your arms or legs after being hit or falling?			
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			40. Have you ever become ill while exercising in the heat?			
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			41. Do you get frequent muscle cramps when exercising?			
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			42. Do you or someone in your family have sickle cell trait or disease?			
BONE AND JOINT QUESTIONS			YES	NO		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			43. Have you had any problems with your eyes or vision?			
18. Have you ever had any broken or fractured bones or dislocated joints?			44. Have you had any eye injuries?			
19. Have you ever had an injury that required x-ray, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			45. Do you wear glasses or contact lenses?			
20. Have you ever had a stress fracture?			46. Do you wear protective eyewear, such as goggles or a face shield?			
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			47. Do you worry about your weight?			
22. Do you regularly use a brace, orthotics, or other assistive device?			48. Are you trying to or has anyone recommended that you gain or lose weight?			
23. Do you have a bone, muscle, or joint injury that bothers you?			49. Are you on a special diet or do you avoid certain types of foods?			
24. Do any of your joints become painful, swollen, feel warm, or look red?			50. Have you ever had an eating disorder?			
25. Do you have any history of juvenile arthritis or connective tissue disease?			51. Do you have any concerns that you would like to discuss with a doctor?			
			FEMALES ONLY		YES	NO
			52. Have you ever had a menstrual period?			
			53. How old were you when you had your first menstrual period?			
			54. How many periods have you had in the last 12 months?			
			<b>Explain "yes" answers here</b>			

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# ATHLETIC PHYSICAL EXAMINATION FORM

To be completed by your physician

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_

Vision: R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
ECG Screening **			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

\*\*HEART SCREENING ECGs will also be offered at on-campus screening events

### PHYSICIANS STATEMENT

An annual physical examination certifying that the student is physically fit to participate in athletics is required before a student may try out, practice, or participate in interscholastic athletic competition. I hereby certify that the above named student was examined by me and found physically fit to engage in interscholastic athletics for the current school year (June 7, 2024 to June 5, 2025).

Date Examined: \_\_\_\_\_ Physician Name: \_\_\_\_\_

PLEASE USE STAMP

Physician Signature: \_\_\_\_\_ Phone: \_\_\_\_\_