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)

lame:		Date of birth:					
Age: Grade: School: Sport(s):							
Medicines and Allergies: Please list all of the prescription a taking.	nd over	-the-cou	nter medicines and supplements (herbal and nutritional) that you ar	e curre	ntly		
Do you have any allergies? □ Yes □ No If yes, plea □ Medicines □ Pollens □ Food □ Stinging inse xplain "Yes" answers below. Circle questions you don't k	cts						
GENERAL QUESTIONS 1. Has a doctor ever denied or restricted your participation in sports	YES	NO	MEDICAL QUESTIONS 26. Do you cough, wheeze, or have difficulty breathing during or	YES	NO		
for any reason?			after exercise?				
Do you have any ongoing medial conditions? If so, please			27. Have you ever used an inhaler or taken asthma medicine?		<u> </u>		
identify below: Asthma Anemia Diabetes Infections			28. Is there anyone in your family who has asthma? 29. Were you born without or are you missing a kidney, an eye, your				
Other:			a testicle (males), or any other organ?		†		
Have you ever spent the night in the hospital?			30. Do you have groin pain or a painful bulge or hernia in the groin				
Have you ever had surgery? HEART HEALTH QUESTIONS ABOUT YOU	YES	NO	area? 31. Have you had infectious mononucleosis (mono) within the last		 		
5. Have you ever passed out or nearly passed out DURING or AFT		140	month?		<u> </u>		
AFTER exercise?			32. Do you have any rashes, pressure sores, or other skin				
6. Have you ever had discomfort, pain, tightness, or pressure in			problems? 33. Have you had a herpes or MRSA skin infection?		ļ		
your chest during exercise? 7. Does your heart ever race or skip beats (irregular beats) during			34. Have you ever had a head injury or concussion?				
exercise?			35. Have you ever had a hit or blow to the head that caused				
8. Has a doctor ever told you that you have any heart problems?			confusion, prolonged headache, or memory problems?				
check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol			36. Do you have a history of seizure disorder? 37. Do you have headaches with exercise?		1		
□ A heart infections □ Kawasaki disease			38. Have you ever had numbness, tingling, or weakness in your				
Other:			after being hit or falling?				
Has a doctor ever ordered a test for your heart? (For example, FOC/FIXO appropriate ream)			39. Have you ever been unable to move your arms or legs after		├ ──		
ECG/EKG, echocardiogram) 10. Do you get lightheaded or feel more short of breath than			being hit or falling? 40. Have you ever become ill while exercising in the heat?		 		
expected during exercise?			41. Do you get frequent muscle cramps when exercising?		<u> </u>		
11. Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or				
12. Do you get more tired or short of breath more quickly than your friends during exercise?			disease? 43. Have you had any problems with your eyes or vision?		-		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	YES	NO	44. Have you had any eye injuries?				
13. Has any family member or relative died of heart problems or had			45. Do you wear glasses or contact lenses?				
an unexpected or unexplained sudden death before age of 50			46. Do you wear protective eyewear, such as goggles or a face				
(including drowning, unexplained car accident, or sudden infant death syndrome)?			shield? 47. Do you worry about your weight?		-		
14. Does anyone in your family have hypertrophic cardiomyopathy,			48. Are you trying to or has anyone recommended that you gain or		1		
Marfan syndrome, arrhythmogenic right ventricular			lose weight?				
cardiomyopathy, long QT syndrome, short QT syndrome,			49. Are you on a special diet or do you avoid certain types of foods?		├ ──		
Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			50. Have you ever had an eating disorder?51. Do you have any concerns that you would like to discuss with		 		
15. Does anyone in your family have a heart problem, pacemaker,			a doctor?				
or implanted defibrillator?			FEMALES ONLY	YES	NO		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			52. Have you ever had a menstrual period?53. How old were you when you had your first menstrual period?		-		
BONE AND JOINT QUESTIONS	YES	NO	54. How many periods have you had in the last 12 months?		 		
17. Have you ever had an injury to a bone, muscle, ligament, or							
tendon that caused you to miss a practice or a game?			Explain "yes" answers here				
18. Have you ever had any broken or fractured bones or dislocated joints?		+			 		
19. Have you ever had an injury that required x-ray, 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? (Down syndrome or		+					
dwarfism)							
22. Do you regularly use a brace, orthotics, or other assistive device?					lacksquare		
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	}				1		
look red?					†		
25. Do you have any history of juvenile arthritis or connective tissue							
disease?			•	1			

Date: _____

Signature of parent/guardian:

ATHLETIC PHYSICAL EXAMINATION FORM

To be completed by your physician

Name: _____

_____ DOB: _____

Height:	Weight:	Pulse:		BP/			
Vision: R 20/	L 20/_	Correcte	ed Y N	Pupils: Equal	Unequal		
		NORMAL		ABNORMAL FIN	NDINGS	INITIALS	
MEDICAL							
Appearance							
Eyes/Ears/Nos	se/Throat						
Hearing							
Lymph Nodes							
Heart							
ECG Screening	, **						
Murmurs							
Pulses							
Lungs							
Abdomen							
Genitourinary	(males only)						
Skin							
MUSCULOSKE	LETAL						
Neck							
Back							
Shoulder/Arm							
Elbow/Foreari	m						
Wrist/Hand/Fi	ingers						
Hip/Thigh							
Knee							
Leg/Ankle							
Foot/Toes							
**HEART SCRE	ENING ECGs wil	ll also be offered a	at on-cam	npus screening events			
		<u> </u>	PHYSICIA	NS STATEMENT			
may try out, prac	ctice, or participa	te in interscholastic	athletic c	ompetition. I hereby cer	e in athletics is required b tify that the above name Irrent school year (June 7	d student was	
Date Examined	:	P	hysician I	Name:			
			,	PLEASE USE STA	AMP		
Physician Signa	ture:			Phone:			