# PREPARTICIPATION PHYSICAL 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:<br>Sex assigned at birth (F, M, or intersex): | Sport(s):<br>How do you identify your gender? (F, M, or other): |
| list past and current medical conditions                           |   |

Lisi pasi ana curreni medical conditions.

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

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

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

| Patient Health Questionnaire Version 4 (PHQ-4)   |            |              |                    |                  |  |  |  |
|--|------------|--------------|--------------------|------------------|--|--|--|
| Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number) |            |              |                    |                  |  |  |  |
|  | 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  | Πo         | $\Box$ 1     | 2                  | 3                |  |  |  |
| Feeling down, depressed, or hopeless   | 0          | 1            | 2                  | 3                |  |  |  |
| (A sum of $\geq$ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)  |            |              |                    |                  |  |  |  |

| ,    |  |     |    | Desne | 1 212     |
|------|--|-----|----|-------|-----------|
| (Exp | VERAL QUESTIONS<br>plain "Yes" answers at the end of this form.<br>le questions if you don't know the answer.)       | Yes | No |       | HE<br>(CC |
| 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?                                |     |    |       | 10        |
| 3.   | Do you have any ongoing medical issues or recent illness?  |     |    | 1     | HE        |
| HEA  | RT HEALTH QUESTIONS ABOUT YOU  | Yes | No |       |           |
| 4.   | Have you ever passed out or nearly passed out during or after exercise?  |     |    | ]     |           |
| 5.   | Have you ever had discomfort, pain, tightness,<br>or pressure in your chest during exercise?                         |     |    |       | 12        |
| 6.   | Does your heart ever race, flutter in your chest,<br>or skip beats (irregular beats) during exercise?                |     |    |       |           |
| 7.   | Has a doctor ever told you that you have any heart problems?   |     |    |       |           |
| 8.   | Has a doctor ever requested a test for your<br>heart? For example, electrocardiography (ECG)<br>or echocardiography. |     |    |       | 13.       |

|     | ART HEALTH QUESTIONS ABOUT YOU<br>INTINUED)   | Yes | No |
|-----|---|-----|----|
| 9.  | Do you get light-headed or feel shorter of breath<br>than your friends during exercise?   |     |    |
| 10. | Have you ever had a seizure?  |     |    |
| HEA | RT HEALTH QUESTIONS ABOUT YOUR FAMILY   | Yes | No |
| 11. | Has any family member or relative died of heart<br>problems or had an unexpected or unexplained<br>sudden death before age 35 years (including<br>drowning or unexplained car crash)?   |     |    |
| 12. | Does anyone in your family have a genetic heart<br>problem such as hypertrophic cardiomyopathy<br>(HCM), Marfan syndrome, arrhythmogenic right<br>ventricular cardiomyopathy (ARVC), long QT<br>syndrome (LQTS), short QT syndrome (SQTS),<br>Brugada syndrome, or catecholaminergic poly-<br>morphic ventricular tachycardia (CPVT)? |     |    |
| 13. | Has anyone in your family had a pacemaker or<br>an implanted defibrillator before age 3 <i>5</i> ?  |     |    |

| BON | E AND JOINT QUESTIONS  | Yes No | MEDIC                 |
|-----|--|--------|-----------------------|
| 14. | Have you ever had a stress fracture or an injury<br>to a bone, muscle, ligament, joint, or tendon that<br>caused you to miss a practice or game?           |        | 25. D<br>26. A        |
| 15. | Do you have a bone, muscle, ligament, or joint<br>injury that bothers you?   |        | 27. A                 |
| MED | ICAL QUESTIONS   | Yes No | 28. H                 |
| 16. | Do you cough, wheeze, or have difficulty<br>breathing during or after exercise?  |        | FEMAL                 |
| 17. | Are you missing a kidney, an eye, a testide<br>(males), your spleen, or any other organ?   |        | 30. H                 |
| 18. | Do you have groin or testicle pain or a painful<br>bulge or hernia in the groin area?  |        | 31. V                 |
| 19. | Do you have any recurring skin rashes or<br>rashes that come and go, including herpes or<br>methicillin-resistant <i>Staphylococcus aureus</i><br>(MRSA)?  |        | 32. H<br>m<br>Explain |
| 20. | Have you had a concussion or head injury that<br>caused confusion, a prolonged headache, or<br>memory problems?  |        |                       |
| 21. | Have you ever had numbness, had tingling, had<br>weakness in your arms or legs, or been unable<br>to move your arms or legs after being hit or<br>falling? |        |                       |
| 22. | Have you ever become ill while exercising in the heat?   |        |                       |
| 23. | Do you or does someone in your family have<br>sickle cell trait or disease?  |        |                       |
| 24. | Have you ever had or do you have any prob-<br>lems with your eyes or vision?   |        |                       |

| the second s |     |    |
|--|-----|----|
| MEDICAL QUESTIONS (CONTINUED)  | Yes | No |
| 25. Do you worry about your weight?  |     |    |
| 26. Are you trying to or has anyone recommended that you gain or lose weight?                                  |     |    |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups?                           |     |    |
| 28. Have you ever had an eating disorder?  |     |    |
| FEMALES ONLY   | Yes | No |
| 29. Have you ever had a menstrual period?  |     |    |
| 30. How old were you when you had your first menstrual period?   |     |    |
| 31. When was your most recent menstrual period?  |     |    |
| 32. How many periods have you had in the past 12 months?   |     |    |
| 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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# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

#### Name:

### 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, 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?
- · 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?
- Do you wear a seat belt, use a helmet, and use condoms?
- 2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

| Height:  |                   | Weight:           |   |                      |              | 4.4     |          |                             |
|--|-------------------|-------------------|---|----------------------|--------------|---------|----------|-----------------------------|
| BP: /  | ( / )             | Pulse:            | Vision: R 20/   | . L 20/              | Correcte     | ed: 🗌   | ΥĽ       | ЛN                          |
| MEDICAL  | F ANY AND T       |                   |   | Salah 200            |              | NORN    | AL       | ABNORMAL FINDINGS           |
| Appearance   |                   |                   | 202 10  |                      |              |         | 7        |                             |
|  |                   |                   | d palate, pectus excavatum, an  | achnodactyly, hyperl | axity,       |         |          |                             |
| and an other statement of the statement of |                   | se [MVP], and a   | ortic insufficiency)  |                      |              |         | -        |                             |
| Eyes, ears, nos  |                   |                   |   |                      |              | <b></b> | 1        |                             |
| Pupils equa  | 1                 |                   |   |                      |              |         |          |                             |
| Hearing  |                   |                   |   |                      |              | -1      | -        |                             |
| Lymph nodes  |                   |                   |   |                      |              |         | 1        |                             |
| Heart <sup>a</sup>   | uscultation stand | ling auscultation | supine, and ± Valsalva maneu  | verl                 |              |         |          |                             |
| Lungs  |                   |                   |   |                      |              |         | <u> </u> |                             |
| Abdomen  |                   |                   |   |                      |              |         | 1        |                             |
| Skin   |                   |                   | and the second se |                      |              |         |          | 1                           |
|  | olex virus (HSV), | lesions suggestiv | e of methicillin-resistant Staphy   | lococcus aureus (MR  | SA), or      |         | 1        |                             |
| tinea corpo  |                   |                   |   |                      |              |         | 1        |                             |
| Neurological   |                   |                   |   |                      |              | L       |          |                             |
| MUSCULOSKE   | LETAL             |                   |   |                      |              | NORM    | AL       | ABNORMAL FINDINGS           |
| Neck   |                   |                   |   |                      |              |         |          |                             |
| Back   |                   |                   |   |                      |              |         |          |                             |
| Shoulder and a   | Irm               |                   |   |                      |              |         |          |                             |
| Elbow and fore   | arm               |                   |   |                      |              |         |          |                             |
| Wrist, hand, ar  | nd fingers        |                   |   |                      |              |         |          |                             |
| Hip and thigh  |                   |                   |   |                      |              |         |          |                             |
| Клее   |                   |                   |   |                      |              |         |          |                             |
| Leg and ankle  |                   |                   |   |                      |              |         |          |                             |
| Foot and toes  |                   |                   |   |                      |              |         |          |                             |
| Functional   |                   |                   |   |                      | - 1          |         | 1        |                             |
|  |                   |                   | nd box drop or step drop test   |                      |              | L       | 1        |                             |
|  | ocardiography (I  | ECG), echocardia  | ography, referral to a cardiolog  | ist for abnormal car | diac history | or exc  | amin     | ation findings, or a combi- |
| nation of those.   | <i>c</i> .        |                   |   |                      |              |         | -        |                             |
|  | care protessiona  |                   |   |                      |              |         |          | e:                          |
| Address:<br>Signature of hea   | lul               |                   |   |                      | Pho          | ne:     |          | , MD, DO, NP, or PA         |
| Signature of hea   | in care proressio | onai:             |   |                      |              |         |          | , MU, DO, NP, OF PA         |

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

### ■ PREPARTICIPATION PHYSICAL EVALUATION

# MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_

- ·

Medically eligible for all sports without restriction

Addically eligible for all sports without restriction with recommendations for further evaluation or treatment of

Medically eligible for certain sports

Not medically eligible pending further evaluation

□ Not medically eligible for any sports

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).

Date of birth:

| Name of health care professional (print or type): | Date:  |                     |
|---|--------|---------------------|
| Address:  | Phone: |                     |
| Signature of health care professional:            |        | , MD, DO, NP, or PA |
| SHARED EMERGENCY INFORMATION                      |        |                     |
| Allergies:  |        |                     |
|   |        |                     |
|   |        |                     |
| Medications:                                      |        |                     |
|   |        |                     |
|   |        |                     |
| Other information:                                |        |                     |
|   |        |                     |
|   |        |                     |
| Emergency contacts:                               |        |                     |
|   |        |                     |

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