## 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 Litali				
Name				Date of birth
	_ Age			
Medicines a	and Allergies: Pl	ease list all of the prescrip	ntion and over-the-counter medicine	es and supplements (herbal and nutritional) that you are currently taking
Do you have	any allergies?	□ Yes ■ No If ye ■ Pollen	es, please identify specific allergy b s	

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

Data of Evam

GENERAL QUESTIONS			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			27. Have you ever used an inhaler or taken asthma medicine?		
	below: 🗆 Asthma 🔲 Anemia 🔲 Diabetes 🖾 Infections			28. Is there anyone in your family who has asthma?		
3.	Other:			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
4.	Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?		
HE	ART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
5.	Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?		
	AFTER exercise?			33. Have you had a herpes or MRSA skin infection?		
6.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Have you ever had a head injury or concussion?		
7.	Does your heart ever race or skip beats (irregular beats) during exercise?			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
8.	Has a doctor ever told you that you have any heart problems? If so,			36. Do you have a history of seizure disorder?		
	check all that apply:			37. Do you have headaches with exercise?		
	High blood pressure       A heart murmur         High cholesterol       A heart infection			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
9.	Kawasaki disease Other:			39. Have you ever been unable to move your arms or legs after being hit or falling?		
10	Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat?		
	during exercise?			41. Do you get frequent muscle cramps when exercising?		
11.	Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?		
12.	Do you get more tired or short of breath more quickly than your friends			43. Have you had any problems with your eyes or vision?		
	during exercise?			44. Have you had any eye injuries?		
	ART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?		
13.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including			46. Do you wear protective eyewear, such as goggles or a face shield?		
	drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		
14.	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT			48. Are you trying to or has anyone recommended that you gain or lose weight?		
	syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of foods?		
15	Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?		
13.	implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		
16.	Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
	seizures, or near drowning?			52. Have you ever had a menstrual period?		
BO	NE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period?		
17.	Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			54. How many periods have you had in the last 12 months? 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-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?					
20.	Have you ever had a stress fracture?			1		
	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?					
	Do you have a bone, muscle, or joint injury that bothers you?			·		
	Do any of your joints become painful, swollen, feel warm, or look red?					
	Do you have any history of juvenile arthritis or connective tissue disease?			1		

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

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# PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date	of Exam						
Name	me Date of birth						
Sex		Grade		Sport(s)			
1. 1	ype of disability						
2. [	Date of disability						
3. (	Classification (if available)						
4. (	Cause of disability (birth, dise	ase, accident/trauma, oth	er)				
5. l	ist the sports you are interes	sted in playing					
					Yes	No	
6. I	Do you regularly use a brace,	assistive device, or prostl	netic?				
7. [	Do you use any special brace	or assistive device for sp	orts?				
8. I	)o you have any rashes, pres	sure sores, or any other s	kin problems?				
9. I	)o you have a hearing loss? I	Do you use a hearing aid?					
10. [	10. Do you have a visual impairment?						
11. [	11. Do you use any special devices for bowel or bladder function?						
12. [	Oo you have burning or disco	mfort when urinating?					
13. I	13. Have you had autonomic dysreflexia?						
14. I	4. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?						
15. l	15. Do you have muscle spasticity?						
16. I	Do you have frequent seizure	s that cannot be controlle	d by medication?				

Explain "yes" answers here

## Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

### Explain "yes" answers here

#### 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

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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, 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).

CAAIVII	INATION												
Height				Weight			□ Male	□ Female					
BP	/	(	/	)	Puls	е	Vision R	20/	L 20/	Corrected	ПΥ	□ N	
MEDIC	AL							NORMAL		ABNORMAL FIN	DINGS		
Appear Mar arm		ohoscoliosis, lyperlaxity, m	high-a 1yopia,	arched p MVP, ac	alate, pect rtic insuffi	tus excavatum, arachr iciency)	nodactyly,						
	ars/nose/throat ils equal ring												
Lymph	nodes												
	murs (auscultation ation of point of r				salva)								
Pulses	ultaneous femora	and radial	nuleoe										
Lungs			puises						1				_
Abdom	en												-
	urinary (males on	ly) <sup>b</sup>											_
Skin • HSV	, lesions suggest		tinea	corporis									
Neurol	ogic °												
MUSC	ULOSKELETAL												
Neck													
Back													
Should													
Elbow/	forearm												
Wrist/h	and/fingers												
Hip/thi	gh												
Knee													
Leg/an													
Foot/to	es												
Functio	onal k-walk, single le	g hop											

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. <sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

□ Cleared for all sports without restriction

Cleared for a	Il sports without restriction with recommendations for further evaluation or treatment for
	·
□ Not cleared	
	Pending further evaluation
	For any sports
	For certain sports
	Reason
Recommendation	18

I have examined the above-named student and completed the preparticipation 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).

Name of physician (print/type)	Date
Address	Phone
Signature of physician	, MD or D0

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Date of birth \_

## PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name	Sex 🗆 M 🗆 F Age	Date of birth
□ Cleared for all sports without restriction		
□ Cleared for all sports without restriction with recommendations for	or further evaluation or treatment for	
□ Not cleared		
Pending further evaluation		
□ For any sports		
□ For certain sports		
Reason		
Recommendations		
clinical contraindications to practice and participate in the and can be made available to the school at the request o the physician may rescind the clearance until the problem (and parents/guardians).	f the parents. If conditions arise after the m is resolved and the potential consequer	athlete has been cleared for participation, nces are completely explained to the athlete
Name of physician (print/type)		
Address		
Signature of physician		, MD 01 DO
EMERGENCY INFORMATION		
Allergies		
Other information		

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