PREPARTICIPATION PHYSICAL HISTORY FORM

(Note: This is to be filled out by the athlete and parent prior to seeing the physician.)

Name: _____ Date of Birth: _____ / _____ / _____ Age: _____

Sex : _____ Sport(s): _____ Year (circle) 1 2 3 4 5 6

Medicines and Allergies: Please list all of the prescription and over-the-counter medications 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 answers to.

GENERAL QUESTIONS	YES	NO
1 Has a doctor ever denied or restricted your participation in sports for any reason:?		
2. Do you have any ongoing medical conditions? If so, please identify: Asthma Anemia Diabetes Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise:?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ❑ High blood pressure ❑ A heart murmur ❑ High cholesterol ❑ A heart infection ❑ Kawasaki disease ❑ Other:		
9. Has a doctor ever ordered a test for your heart:? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
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	**YES**	**NO**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defribrillator?		
16. Does anyone in your family have unexplained fainting, unexplained seizures, or near drowning?		
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?		
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?		
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?		
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	YES	NO
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
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?		
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 eye wear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you 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 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 month?		

Explain "YES" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of Athlete _____ **Signature of parent/guardian** _____

If athlete is a minor

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Preparticipation Physical Examination Form

Name: _____ Date of Birth _____ / _____ / _____

Physician Reminders

1. Do you feel stressed on more sensitive issues?
2. Do you ever feel sad, hopeless, depressed, or anxious?
3. Do you feel safe at your home or residence?
4. Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
5. During the last 30 days, did you use chewing tobacco, snuff, or dip?
6. Do you drink alcohol or use any other drugs?
7. Have you ever taken anabolic steroids or used any other performance supplement?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Do you wear a seat belt, use a helmet, and use condoms?

EXAMINATION				
Height	Weight	❑ Male ❑ Female		
BP / (/) Pulse	Vision Rt. 20 /	Lt . 20/	Corrected	❑ Yes ❑ No

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, standing, +/- 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	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional Duck walk, single leg hop		

Consider reviewing questions on cardiovascular symptoms (History questions 5-14)

[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 athlete 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 athlete and/or 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 DO

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