

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your pa	,	
Name:		
ex: M/F		
List past and current medical conditions		
Have you ever had surgery? If yes, list all past s	urgical procedures	
Medicines and supplements: List all current pre	escriptions, over-the-counter n	nedicines, and supplements (herbal and nutritional).
Do you have any allergies? If yes, please list al	ll your allergies (ie, medicine	s, 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 numbers)							
	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	0	1	2	3			
Feeling down, depressed, or hopeless	0	1	2	3			
(A sum of ≥3 is considered positive on either	r subscale [question	ns 1 and 2, or que	stions 3 and 4] for scre	ening purposes.)			

(Ехр	IERAL QUESTIONS lain "Yes" answers at the end of this form. e questions if you don't know the answer.)	Yes	No
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?		
3.	Do you have any ongoing medical issues or recent illness?		
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, or pressure in your chest during exercise?		
6.	Does your heart ever race, flutter in your chest, 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 heart? For example, electrocardiography (ECG) or echocardiography.		

	RT HEALTH QUESTIONS ABOUT YOU NTINUED)	Yes	No
9.	Do you get light-headed or feel shorter of breath 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 problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12.	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BOV	IE AND JOINT QUESTIONS	Yes	No		MED	ICAL QUESTIONS (CONTIL
4.	Have you ever had a stress fracture or an injury				25.	Do you worry about your
	to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?				26.	Are you trying to or has a that you gain or lose weig
i.	Do you have a bone, muscle, ligament, or joint injury that bothers you?				27.	Are you on a special diet certain types of foods or f
ED	OICAL QUESTIONS	Yes	No		28.	Have you ever had an ea
).	Do you cough, wheeze, or have difficulty breathing during or after exercise?					ALES ONLY
7.	Are you missing a kidney, an eye, a testicle			1	-	Have you ever had a men How old were you when y
_	(males), your spleen, or any other organ?				30.	menstrual period?
	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?				31.	When was your most rece
	Do you have any recurring skin rashes or rashes that come and go, including herpes or				32.	How many periods have y months?
			l			
	methicillin-resistant Staphylococcus aureus (MRSA)?				Explo	iin "Yes" answers her
-	methicillin-resistant Staphylococcus aureus			_	Explo	iin "Yes" answers hei
	methicillin-resistant Staphylococcus aureus (MRSA)? Have you had a concussion or head injury that caused confusion, a prolonged headache, or			_	Explo	iin "Yes" answers hei
1.	methicillin-resistant Staphylococcus aureus (MRSA)? Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or			-	Explo	nin "Yes" answers her
2.	methicillin-resistant Staphylococcus aureus (MRSA)? Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? Have you ever become ill while exercising in the			-	Explo	nin "Yes" answers he

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?		

xpiain "Te	s" answers h	ere.	

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

ignature of athlete:
ignature of parent or guardian:
Date:

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■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name:	Date of birth:

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).

EXAMINATION			
Height: Weight:			
BP: / (/) Pulse: Vision: R 20/ L 20/	Correc	ted: 🗆 Y 🛚	□N
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance			
Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hype	erlaxity,		
myopia, mitral valve prolapse [MVP], and aortic insufficiency)			
Eyes, ears, nose, and throat			
Pupils equal			
Hearing			
Lymph nodes			
Hearto			
Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)			
Lungs			
Abdomen			
Skin	ADCA)		
 Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (National corporis 	IKSA), or		
Neurological			
MUSCULOSKELETAL		NORMAL	ABNORMAL FINDINGS
Neck		110101012	7.51 (01015 12 111 (511 (50
Back			
Shoulder and arm			
Elbow and forearm			
Wrist, hand, and fingers			
Hip and thigh			
Knee			
Leg and ankle			
Foot and toes			
Functional			
Double-leg squat test, single-leg squat test, and box drop or step drop test			
Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal c	ardiac histo	ry or examin	ation findinas, or a combi-
nation of those.		,	
Name of health care professional (print or type):		Dat	e:
Address:			
Signature of health care professional:			, MD, DO, NP, or PA

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PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM Date of birth: Name: ☐ Medically eligible for all sports without restriction ☐ Medically 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 \square 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). Address: Phone: Signature of health care professional: , MD, DO, NP, or PA SHARED EMERGENCY INFORMATION Allergies: Medications: Other information: _____ Emergency contacts: ____