■ 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.)

•			ng the p	onysician. The physician should keep uns form in the chart.)					
Date of Exam									
			Date of birth						
Sex Age (Age Grade Sch			Sport(s)					
Madicines and Allender Discouling	-11 - £ 11	41		adiciona and consultance de Acade I and a deliciona Debat and a second	A = 1 -2				
Medicines and Allergies: Please list a	all of the prescription and over-	-tne-coi	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking				
-									
Do you have any allergice?	no □ No If you places idea	tifu one	oific all	lovey below					
Do you have any allergies? ☐ Ye ☐ Medicines	es No If yes, please ider Pollens	illiy spe	ecilic all	□ Food □ Stinging Insects					
Fundain "Vaa" anawaya balayy Civala su	antions was doubt know the on								
Explain "Yes" answers below. Circle qu	estions you don't know the an			MEDICAL QUESTIONS	Yes	No			
GENERAL QUESTIONS	our participation in aparts for	Yes	No	26. Do you cough, wheeze, or have difficulty breathing during or	162	NO			
 Has a doctor ever denied or restricted y any reason? 	our participation in sports for			after exercise?					
2. Do you have any ongoing medical condi				27. Have you ever used an inhaler or taken asthma medicine?					
below: ☐ Asthma ☐ Anemia ☐ Other:	Diabetes 🗆 Infections			28. Is there anyone in your family who has asthma?					
3. Have you ever spent the night in the ho	snital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?					
Have you ever had surgery?	opital.			30. Do you have groin pain or a painful bulge or hernia in the groin area?					
HEART 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 pass	sed 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, tight chest during exercise?	ntness, or pressure in your			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	e any heart problems? If so,			36. Do you have a history of seizure disorder?	\vdash				
check all that apply: ☐ High blood pressure ☐ A h	eart murmur			37. Do you have headaches with exercise?					
	eart infection			38. Have you ever had numbness, tingling, or weakness in your arms or					
☐ Kawasaki disease Other:				legs after being hit or falling?					
Has a doctor ever ordered a test for you echocardiogram)	r heart? (For example, ECG/EKG,			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 sho	ort of breath than expected			40. Have you ever become ill while exercising in the heat?					
during exercise?	0			41. Do you get frequent muscle cramps when exercising?					
11. Have you ever had an unexplained seizu12. Do you get more tired or short of breath				42. Do you or someone in your family have sickle cell trait or disease?					
during exercise?	i more quickly man your menus			43. Have you had any problems with your eyes or vision? 44. Have you had any eye injuries?	\vdash				
HEART HEALTH QUESTIONS ABOUT YOUR	R FAMILY	Yes	No	45. Do you wear glasses or contact lenses?					
13. Has any family member or relative died				46. Do you wear protective eyewear, such as goggles or a face shield?					
unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?				47. Do you worry about your weight?					
14. Does anyone in your family have hypert	rophic cardiomyopathy, Marfan			48. Are you trying to or has anyone recommended that you gain or					
syndrome, arrhythmogenic right ventric syndrome, short QT syndrome, Brugada				lose weight?					
polymorphic ventricular tachycardia?	oynaromo, or oatoonolammorgio			49. Are you on a special diet or do you avoid certain types of foods? 50. Have you ever had an eating disorder?	\vdash				
15. Does anyone in your family have a hear	t problem, pacemaker, or			51. Do you have any concerns that you would like to discuss with a doctor?					
implanted defibrillator? 16. Has anyone in your family had unexplain	ned fainting unevalained			FEMALES ONLY					
seizures, or near drowning?	neu rainting, unexplaineu			52. Have you ever had a menstrual period?					
BONE 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, i	, 0			54. How many periods have you had in the last 12 months?	L				
that caused you to miss a practice or a 18. Have you ever had any broken or fractu	0			Explain "yes" answers here					
19. Have you ever had an injury that require	· · · · · · · · · · · · · · · · · · ·								
injections, therapy, a brace, a cast, or cr									
20. Have you ever had a stress fracture?									
21. Have you ever been told that you have of instability or atlantoaxial instability? (Do									
22. Do you regularly use a brace, orthotics,									
23. Do you have a bone, muscle, or joint inju									
24. Do any of your joints become painful, sv									
25. Do you have any history of juvenile arth	ritis or connective tissue disease?]					
I hereby state that, to the best of my	knowledge, my answers to t	he abo	ve que	stions are complete and correct.					
Signature of athlete	Signature o	f parent/a	uardian	Date					

■ 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, 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 que	estions on car	diovascula	ar sym	ptoms (questions 5–14).						
EXAMINATION										
Height		Weig	ght		☐ Male	☐ Female				
BP /	(/)	Pulse	Vision F	R 20/	L 20/	Correct	ed 🗆 Y	□N
MEDICAL	,		,			NORMAL		ABNORMAL		
Appearance				e, pectus excavatum, arac insufficiency)	chnodactyly,					
Eyes/ears/nose/throat Pupils equal Hearing										
Lymph nodes Heart a • Murmurs (auscultation • Location of point of m			/alsalv	/a)						
Pulses • Simultaneous femoral	· ·	, ,								
Lungs										
Abdomen										
Genitourinary (males only	/) ^b									
Skin • HSV, lesions suggestive	re of MRSA, tir	nea corpo	ris							
Neurologic °										
MUSCULOSKELETAL										
Neck										
Back										
Shoulder/arm										
Elbow/forearm										
Wrist/hand/fingers							+			
Hip/thigh										
Knee Leg/ankle							+			
Foot/toes										
Functional										
Duck-walk, single leg	hop									
^a Consider ECG, echocardiogram ^b Consider GU exam if in private ^c Consider cognitive evaluation	e setting. Having	third party	presen	t is recommended.						
☐ Cleared for all sports v	vithout restric	tion								
☐ Cleared for all sports v	vithout restric	tion with r	ecom	mendations for further eva	aluation or treatme	nt for				
□ Not cleared										
•	further evalua	ition								
☐ For any s	sports									
□ For certa	ain sports									
Reason										
Recommendations										
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/ty	vne)								Date	
Address	, he)								Date	
Signature of physician										, MD or DO