■ 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.)

		sconig	, inc p	энувылан. Тне рнувылан вноши кеер инв юти иг ине спан.)				
Date of Exam								
				Date of birth				
Sex Age Grade	School		Sport(s)					
Mandistran and Allermine Discoulint all of the			4	adi di ang ang di ang alam ang di ang alam di ang d	A = 1 -2			
Medicines and Allergies: Please list all of the	prescription and over-th	e-coun	ter m	edicines and supplements (herbal and nutritional) that you are currently	taking			
-								
De you have any allergies?	la If you place identif	u anaoi	fic all	orgu balau				
	lo If yes, please identif Pollens	y speci	iic aii	ergy below. □ Food □ Stinging Insects				
Fundain "Van" anguara balaw Cirala ayaatiana y	au danik kaassi tha anassi							
Explain "Yes" answers below. Circle questions you don't know the an						Yes No		
GENERAL QUESTIONS		/es	No	26. Do you cough, wheeze, or have difficulty breathing during or	162	NO		
 Has a doctor ever denied or restricted your partici any reason? 	pation in sports for			after exercise?				
2. Do you have any ongoing medical conditions? If so				27. Have you ever used an inhaler or taken asthma medicine?				
below: ☐ Asthma ☐ Anemia ☐ Diabetes Other:	☐ Infections			28. Is there anyone in your family who has asthma?				
3. Have you ever spent the night in the hospital?				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?				30. Do you have groin pain or a painful bulge or hernia in the groin area?				
HEART HEALTH QUESTIONS ABOUT YOU	١	/es	No	31. Have you had infectious mononucleosis (mono) within the last month?				
5. Have you ever passed out or nearly passed out DU	IRING 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 chest during exercise?	oressure 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 any hear	t problems? If so,			36. Do you have a history of seizure disorder?	\vdash			
check all that apply: ☐ High blood pressure ☐ A heart murm	LIF.			37. Do you have headaches with exercise?				
☐ High cholesterol ☐ A heart infecti				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 your heart? (F echocardiogram)	or 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 short of breat	h 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?12. Do you get more tired or short of breath more quie	kly than your friends			42. Do you or someone in your family have sickle cell trait or disease?				
during exercise?	Kiy tilali 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 FAMILY	١	/es	No	45. Do you wear glasses or contact lenses?				
13. Has any family member or relative died of heart p				46. Do you wear protective eyewear, such as goggles or a face shield?				
unexpected or unexplained sudden death before a drowning, unexplained car accident, or sudden inf				47. Do you worry about your weight?				
14. Does anyone in your family have hypertrophic car	diomyopathy, Marfan			48. Are you trying to or has anyone recommended that you gain or				
syndrome, arrhythmogenic right ventricular cardic syndrome, short QT syndrome, Brugada syndrome				lose weight?				
polymorphic ventricular tachycardia?	, or outcomoraninorgio			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 heart 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 unexplained faintin	n unevnlained			FEMALES ONLY				
seizures, or near drowning?	g, unexplained			52. Have you ever had a menstrual period?				
BONE AND JOINT QUESTIONS	١	/es	No	53. How old were you when you had your first menstrual period?				
17. Have you ever had an injury to a bone, muscle, lig	ament, or tendon			54. How many periods have you had in the last 12 months?	L			
that caused you to miss a practice or a game? 18. Have you ever had any broken or fractured bones	or dislocated injute?			Explain "yes" answers here				
19. Have you ever had an injury that required x-rays,								
injections, therapy, a brace, a cast, or crutches?	, , , , , , , , , , , , , , , , , , , ,							
20. Have you ever had a stress fracture?				- 				
 Have you ever been told that you have or have you instability or atlantoaxial instability? (Down syndromatics) 								
22. Do you regularly use a brace, orthotics, or other as								
23. Do you have a bone, muscle, or joint injury that bo								
24. Do any of your joints become painful, swollen, fee	-							
25. Do you have any history of juvenile arthritis or con	nective tissue disease?							
I hereby state that, to the best of my knowled	lge, my answers to the	above	ques	stions are complete and correct.				
Signature of athlete	Signature of pa	rent/quar	dian	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 ques	stions on cardio	ovascular s	sympton	ms (questions 5–14).						
EXAMINATION										
Height		Weight		☐ Male	☐ Female					
BP /	(/)		ulse Vision F	R 20/	L 20/ Corrected □ Y □ N				
MEDICAL		<u>, , , , , , , , , , , , , , , , , , , </u>			NORMAL	ABNORMAL FINDINGS				
Appearance				ectus excavatum, arachnodactyly, ufficiency)						
Eyes/ears/nose/throat Pupils equal Hearing										
Lymph nodes Heart a • Murmurs (auscultation			salva)							
 Location of point of ma Pulses Simultaneous femoral a 										
Lungs	and radial puls	55								
Abdomen										
Genitourinary (males only)	b									
Skin HSV, lesions suggestive	e of MRSA, tine	a corporis								
Neurologic ^c										
MUSCULOSKELETAL										
Neck										
Back										
Shoulder/arm										
Elbow/forearm										
Wrist/hand/fingers										
Hip/thigh										
Knee										
Leg/ankle Foot/toes										
Functional										
Duck-walk, single leg h										
Consider ECG, echocardiogram, Consider GU exam if in private Consider cognitive evaluation o	setting. Having th	ird party pre	esent is re							
☐ Cleared for all sports without restriction										
□ Cleared for all sports without restriction with recommendations for further evaluation or treatment for										
□ Not cleared										
☐ Pending for	urther evaluation	on								
☐ For any sports										
☐ For certain	n 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/tur	ne)					Date				
Address						Phone				
Signature of physician						, MD or D				