## ■ 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.)

ne			Date of birth		
			Sport(s)		
edicines and Allergies: Please list all of the prescription and ov	er-the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking	
o you have any allergies?	entify spe		ergy below.  □ Food □ Stinging Insects		
lain "Yes" answers below. Circle questions you don't know the a	inswers t	0.			
NERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
Has a doctor ever denied or restricted your participation in sports for any reason?			Do you cough, wheeze, or have difficulty breathing during or after exercise?		
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 Other:			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	-	-
Have you ever spent the night in the hospital?			(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?		-
ART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		+
Have you ever passed out or nearly passed out DURING or AFTER exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		+-
Have you ever had discomfort, pain, tightness, or pressure in your			33. Have you had a herpes or MRSA skin infection?      34. Have you ever had a head injury or concussion?		+
chest during exercise?			35. Have you ever had a hit or blow to the head that caused confusion.		+
. Does your heart ever race or skip beats (irregular beats) during exercise	?		prolonged headache, or memory problems?		
. Has a doctor ever told you that you have any heart problems? If so, check all that apply:			36. Do you have a history of seizure disorder?		_
☐ High blood pressure ☐ A heart murmur			37. Do you have headaches with exercise?		+
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		_
. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?		
. 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?	-	+-
Have you ever had an unexplained seizure?      Do you get more tired or short of breath more quickly than your friends	+		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?	-	+
during exercise?			44. Have you had any problems with your eyes of vision:		+
ART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?		+
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?		F
drowning, unexplained car accident, or sudden infant death syndrome)?	-		47. Do you worry about your weight?  48. Are you trying to or has anyone recommended that you gain or		+
<ul> <li>Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT</li> </ul>			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?		_
Does anyone in your family have a heart problem, pacemaker, or	+		50. Have you ever had an eating disorder?	-	1
implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		1
. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
seizures, or near drowning?	Vac	No	52. Have you ever had a menstrual period?	-	
Have you ever had an injury to a hone, muscle, ligament, or tendon	Yes	No	53. How old were you when you had your first menstrual period?  54. How many periods have you had in the last 12 months?	-	
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			Explain "yes" answers here	1	
. Have you ever had any broken or fractured bones or dislocated joints?					
. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?					
. Have you ever had a stress fracture?					
. Have you ever been told that you have or have you had an x-ray for nec instability or atlantoaxial instability? (Down syndrome or dwarfism)	K				
. Do you regularly use a brace, orthotics, or other assistive device?				-	
. Do you have a bone, muscle, or joint injury that bothers you?					-
. Do you have a boile, muscle, or joint injury that bothers you?			I .		
<ul> <li>Do you have a bone, muscle, or joint injury that obtains you?</li> <li>Do any of your joints become painful, swollen, feel warm, or look red?</li> <li>Do you have any history of juvenile arthritis or connective tissue disease</li> </ul>					

## ■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_

1. Consider Do yo Do yo Do yo Have During Do yo Have Have Do yo	u drink alcohol o you ever taken a you ever taken a u wear a seat be	tions on m ut or unde nopeless, c ur home or garettes, c ys, did you r use any nabolic ste ny suppler It, use a h	r a lot of depress reside hewing use ch other d eroids of ments t	of pressured, or an nce? tobacco, lewing to rugs? or used an o help you and use o	re? xious? , snuff, or dip? bacco, snuff, or dip? ny other performanc u gain or lose weigh	e supplement? It or improve your perform	Date of Exam		
EXAMINA	TION		(California	. Sinite					
Height				Weight		□ Male	☐ Female		
BP	1	(	1	)	Pulse	Vision F	20/	L 20/	Corrected  Y N
MEDICAL							NORMAL		ABNORMAL FINDINGS
	stigmata (kypho				ate, pectus excavatu	m, arachnodactyly,			
	an > height, hype nose/throat equal	erlaxity, m	yopia, N	MVP, aorti	c insufficiency)			-	
<ul> <li>Hearing</li> </ul>	1								
Lymph noo	ies								
	rs (auscultation s				lva)				
Pulses	neous femoral a	****							
Lungs									
Abdomen	/1 1.16								
Skin	ary (males only) <sup>b</sup>	8							
	sions suggestive	of MRSA,	tinea c	orporis					
	SKELETAL								
Neck									
Back									
Shoulder/a									
Elbow/fore			-					_	
Wrist/hand	viingers								
Hip/thigh Knee									
Leg/ankle									
Foot/toes									
Functional									
	valk, single leg h	ор							
Consider GU	exam if in private s	etting. Havii	ng third	party prese	bnormal cardiac history ent is recommended, ing if a history of signif				
☐ Cleared	for all sports wit	thout restr	iction						
□ Cleared	for all sports wit	thout restr	iction v	vith recor	nmendations for fur	ther evaluation or treatme	nt for		
☐ Not clea	ared								
	Pending fu	ırther eval	uation						
	☐ For any sp								
	☐ For certain	n sports _							
	Reason								
Recommen	dations								
participate tions arise explained	e in the sport(s) after the athlet to the athlete (a	as outling te has bee and paren	ed abo en clea ts/gua	ve. A copred for predictions.	oy of the physical e articipation, the ph	xam is on record in my ysician may rescind the	office and can be m clearance until the	ade available to t problem is resol	apparent clinical contraindications to practice and the school at the request of the parents. If condi- ved and the potential consequences are completely
									Date
Address									Phone
Signature o	of physician								, MD or DC
Address									Phone

\_\_ Date of birth \_\_\_\_\_