

Preparticipation Physical Evaluation - History Form

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of Birth: _____ Sex: _____

Date of Examination: _____ Sport(s): _____

List past and current medical conditions: _____

Have you ever had surgery? If yes, list all past surgical procedures: _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional): _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects): _____

General Questions. Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No	Medical Questions	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?			16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Has a provider ever denied or restricted your participation in sports for any reason?			17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
3. Do you have any ongoing medical issues or recent illness?			18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
Heart Health Questions About You	Yes	No	19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?			20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling?		
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?			22. Have you ever become ill while exercising in the heat?		
7. Has a doctor ever told you that you have any heart problems?			23. Do you or someone in your family have sickle cell trait or disease?		
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.			24. Have you ever had or do you have any problems with your eyes or vision?		
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?			25. Do you worry about your weight?		
10. Have you ever had a seizure?			26. Are you trying to or has anyone recommended that you gain or lose weight?		
Health Questions About Your Family	Yes	No	27. Are you on a special Diet or do you avoid certain types of foods?		
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car accident)?			28. Have you ever had an eating disorder?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			Females Only	Yes	No
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?			29. Have you ever had a menstrual period?		
Bone and Joint Questions	Yes	No	30. How old were you when you had your first menstrual period?		
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a game or practice?			31. When was your most recent menstrual period?		
15. Do you have a bone, muscle, ligament or joint injury that bothers you?			32. How many periods have you had in the past 12 months?		

Explain a "Yes" answer here: _____

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date _____

Preparticipation Physical Evaluation - Physical Form

 Last Name First Name Middle Initial Date of Birth

Examination			
Height:	Weight:		
BP: / (/)	Pulse:	Vision: R 20/ L 20/	Corrected Yes No

Medical	Normal	Abnormal Findings
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes / Ears / Nose / Throat - Pupils equal / Hearing		
Lymph Nodes		
Heart - Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurologic		
Musculoskeletal:		
- Neck		
- Back		
- Shoulders/Arm		
- Elbow/Forearm		
- Wrist/Hand/Fingers		
- Hip/Thighs		
- Knees		
- Leg/Ankles		
- Foot/Toes		
- Functional: Double-leg squat test, single leg squat test, and box drop or step drop test		

Consider: electrocardiography (ECG), echocardiography, and referral to cardiologist for abnormal cardiac history or examination findings or a combination of those.

Preparticipation Physical Evaluation

- 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.
 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. If conditions arise after the athlete had 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.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____ MD, DO, NP, or PA