PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM



Date of birth Name

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 teel 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?

Doctor's Office: **OFFICIAL STAMP** is required on this Form.

Cleared for all sports without restriction with recommendations for further evaluation or treatment for Not cleared Pending further evaluation For any sports For certain sports Reason Reason Not cleared Pending further evaluation Reason Rea	EXAMINATION				
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ddress Phone	Name of physician (print/type)				Exam Date

■ PREPARTICIPATION PHYSICAL EVALUATION



HISTORY FORM
(Note: This form is to be filled out by the patient and parent prior to seeing the physician.)

Date of Exam					
	Date of birth				
Sex Age Grade Sch	100l <u> </u>		Sport(s)		
Medicines and Allergies: Please list all of the prescription and over	-the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking	
			ue i e e e e e e e e e e e e e e e e e e		
Do you have any allergies? ☐ Yes ☐ No If yes, please ide ☐ Medicines ☐ Pollens	ntify sp	ecific al	lergy below. □ Food □ Stinging Insects		
xplain "Yes" answers below. Circle questions you don't know the an	swers t	0.			
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
 Has a doctor ever denied or restricted your participation in sports for any reason? 			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Do you have any ongoing medical conditions? If so, please identify below: Asthma			27. Have you ever used an inhaler or taken asthma medicine?		
			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 (males), your spleen, or any other organ?	l y	
Have you ever spent the hight in the hospital? 4. Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?		Ī
HEART HEALTH QUESTIONS ABOUT YOU		No	31. Have you had infectious mononucleosis (mono) within the last month?		
5. Have you ever passed out or nearly passed 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?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			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?	1 8	
8. Has a doctor ever told you that you have any heart problems? If so,	8		36. Do you have a history of seizure disorder?		
check all that apply: High blood pressure			37. Do you have headaches with exercise?		
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			38. 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?		
10. 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	<u> </u>		42. Do you or someone in your family have sickle cell trait or disease?		_
during exercise?			43. Have you had any problems with your eyes or vision? 44. Have you had any eye injuries?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		No	45. Do you wear glasses or contact lenses?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			46. Do you wear protective eyewear, such as goggles or a face shield?		
			47. Do you worry about your weight?		İ
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
			49. Are you on a special diet or do you avoid certain types of foods?		
			50. Have you ever had an eating disorder?		
			51. Do you have any concerns that you would like to discuss with a doctor?		
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
seizures, or near drowning? BONE AND JOINT QUESTIONS	Yes	No	52. Have you ever had a menstrual period? 53. How old were you when you had your first menstrual period?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon		NO	54. How many periods have you had in the last 12 months?		
that caused you to miss a practice or a game?			Explain "yes" answers here		
18. Have you ever had any broken or fractured bones or dislocated joints?			Explain job anomolo haro		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?					
20. Have you ever had a stress fracture?					
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)					
22. Do you regularly use a brace, orthotics, or other assistive device?					
23. Do you have a bone, muscle, or joint injury that bothers you?					
24. Do any of your joints become painful, swollen, feel warm, or look red?					
25. Do you have any history of juvenile arthritis or connective tissue disease?					
hereby state that, to the best of my knowledge, my answers to	the ele				