

# 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			Medical Questions	
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No	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
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?			19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?	
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) 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?	
7. Has a doctor ever told you that you have any heart problems?			22. Have you ever become ill while exercising in the heat?	
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.			23. Do you or someone in your family have sickle cell trait or disease?	
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?			24. Have you ever had or do you have any problems with your eyes or vision?	
10. Have you ever had a seizure?			25. Do you worry about your weight?	
Health Questions About Your Family			Yes	No
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)?			26. Are you trying to or has anyone recommended that you gain or lose weight?	
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)?			27. Are you on a special Diet or do you avoid certain types of foods?	
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?			28. Have you ever had an eating disorder?	
Bone and Joint Questions			Yes	No
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?			Females Only	
15. Do you have a bone, muscle, ligament or joint injury that bothers you?			29. Have you ever had a menstrual period?	
			30. How old were you when you had your first menstrual period?	
			31. When was your most recent menstrual period?	
			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
<b>Appearance:</b> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
<b>Eyes / Ears / Nose / Throat</b> - Pupils equal / Hearing		
<b>Lymph Nodes</b>		
<b>Heart</b> - Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
<b>Lungs</b>		
<b>Abdomen</b>		
<b>Skin</b> - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
<b>Neurologic</b>		
<b>Musculoskeletal:</b>		
- 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