PRE-PARTICIPATION PHYSICAL EVALUATION

Note: This section of the form is to be filled out by the student-athlete and/or parent prior to seeing a provider, the provider should stamp or sign the box (right) after review.

Note to Providers: Please stamp or sign in this box to verify you have reviewed the Patient Pre-Participation Health History Form

Provider Signature: _____

Date: _____

HEALTH HISTORY FORM

Name _____ Date of Birth _____

Date of Examination _____ Sport(s) _____

Sex assigned at birth (M, F, or Intersex) _____ How do you identify your gender? (F, M, non-binary, or another) _____

List past and current medical conditions: _____

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

Medications and supplements: List all current prescription and over-the-counter medications, and any supplements (herbal and/or nutritional). _____

Do you have any allergies? If yes, please list all your allergies (i.e., medicines, pollens, food, insects) and allergic reactions.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0 ●	1 ○	2 ○	3 ○
Not being able to stop or control worrying	0 ●	1 ○	2 ○	3 ○
Little interest or pleasure in doing things	0 ●	1 ○	2 ○	3 ○
Feeling down, depressed, or hopeless	0 ●	1 ○	2 ○	3 ○

Note to providers: if a combined score is ≥3, the student should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Please explain any "yes" answers at the end of this form.

GENERAL QUESTIONS	YES	NO
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illnesses?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiographic (ECG) or echocardiography?		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	YES	NO
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART 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 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Bragada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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 practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

Medical Questions	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

Menstrual Questions	N/A	Yes	No
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 "Yes" answers here.

Immunization Records

Have you been immunized for MMR (Measles, Mumps, Rubella), Polio, and Tetanus? ☐ Yes ☐ No

Note: You may be asked to provide the dates of these immunization.

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: _____ Date: _____

Signature of parent or guardian: _____ Date: _____

(only necessary if the student-athlete is under 18 at the time of the physical evaluation)

PART 2: PHYSICAL EXAMINATION FORM

This section of the form must be filled out by a (1) physician possessing an unrestricted license to practice medicine; (2) licensed physician assistant, or (3) certified nurse practitioner who has clinical training and experience in detecting cardiopulmonary diseases and defects.

Date of Exam					
Name				Date of Birth	
Sex		Age		Year in School	
Sport(s)					

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

Medical	**Normal**	**Abnormal Findings**
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart • Murmurs (auscultation standing, supine, with and without Valsalva)		
Pulses		
Lungs		
Abdomen		
Skin		
Neurologic		
Musculoskeletal	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

◯ Cleared for all sports without restrictions

◯ Cleared for all sports without restrictions with recommendations for further evaluations or treatment for:

_____

◯ Not Cleared

- ◯ Pending further evaluation
- ◯ For any sports
- ◯ For certain sports: _____

Reason: _____

Recommendation: _____

_____

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 provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Provider (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of Provider: _____