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.)

Date of Exam

Name                      Date of Exam                  Date of birth

Sex       Age          Grade          School          Sport(s)

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies?  ☐ Yes  ☐ No
If yes, please identify specific allergy below.
☐ Medicines  ☐ Pollens  ☐ Food  ☐ Stinging Insects

Explain “Yes” answers below. Circle questions you don’t know the answers to.

GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections
☐ Other:
3. Have you ever been treated for a chronic medical condition? Yes No
4. Have you ever had surgery? Yes No
5. Have you ever passed out or nearly passed out during or after exercise? Yes No
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Yes No
7. Does your heart ever race or skip beats (irregular beats) during exercise? Yes No
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
☐ High blood pressure  ☐ A heart murmur
☐ High cholesterol  ☐ A heart infection
☐ Kawasaki disease  ☐ Other:
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EGK, echocardiogram) Yes No
10. Do you get lightheaded or feel more short of breath than expected during exercise? Yes No
11. Have you ever had an unexplained seizure? Yes No
12. Do you get more tired or short of breath more quickly than your friends during exercise? Yes No

HEART HEALTH QUESTIONS ABOUT YOU

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)? Yes No
14. 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? Yes No
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes No
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Yes No

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? Yes No
18. Have you ever had any broken or fractured bones or dislocated joints? Yes No
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Yes No
20. Have you ever had a stress fracture? Yes No
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) Yes No
22. Do you regularly use a brace, orthotics, or other assistive device? Yes No
23. Do you have a bone, muscle, or joint injury that bothers you? Yes No
24. Do any of your joints become painful, swollen, feel warm, or look red? Yes No
25. Do you have any history of juvenile arthritis or connective tissue disease? Yes No

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

Signature of athlete
Signature of parent/guardian
Date
Name ___________________________________________ Date of birth _____________________________

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 feel 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?
   • Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION

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<th>Height</th>
<th>Weight</th>
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<th>Female</th>
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MEDICAL

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<th>Normal</th>
<th>Abnormal Findings</th>
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- Appearance
  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)
- Eyes/ears/nose/throat
  - Pupils equal
  - Hearing
- Lymph Nodes
- Heart
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)
- Pulses
  - Simultaneous femoral and radial pulses
- Lungs
- Abdomen
- Genitourinary (males only)*
- Skin
  - HSV, lesions suggestive of MRSA, linea corporis
- Neurologic*c

MUSCULOSKELETAL

- Neck
- Back
- Shoulder/arm
- Elbow/forearm
- Wrist/hand/fingers
- Hip/thigh
- Knee
- Leg/ankle
- Foot/toes
- Functional
  - Duck-walk, single leg hop

*Consider EGG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
*Consider (6) exam if in private setting. Having third party present is recommended.
*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ 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 ___________________________________________

Recommendations ___________________________________________

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

Name of physician (print/type) ___________________________ Date ___________________________
Address ___________________________________________ Phone ___________________________
Signature of physician ___________________________ MD or DO