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 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? ___

2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Anemia □ Diabetes □ Infections Other: ___

3. Have you ever spent the night in the hospital? ___

4. Have you ever had surgery? ___

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out DURING or AFTER exercise? ___

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? ___

7. Does your heart ever race or skip beats (irregular beats) during exercise? ___

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/EKG, echocardiogram) ___

10. Do you get lightheaded or feel more short of breath than expected during exercise? ___

11. Have you ever had an unexplained seizure? ___

12. Do you get more tired or short of breath more quickly than your friends during exercise? ___

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

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)? ___

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? ___

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? ___

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? ___

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? ___

18. Have you ever had any broken or fractured bones or dislocated joints? ___

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 you have 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? ___

MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? ___

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? ___

30. Do you have groin pain or a painful bulge or hernia in the groin area? ___

31. Have you had infectious mononucleosis (mono) within the last month? ___

32. Do you have any rashes, pressure sores, or other skin problems? ___

33. Have you had a herpes or MRSA skin infection? ___

34. Have you ever had a head injury or concussion? ___

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? ___

36. Do you have a history of seizure disorder? ___

37. Do you have headaches with exercise? ___

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ___

39. Have you ever been unable to move your arms or legs after being hit or falling? ___

40. Have you ever become ill while exercising in the heat? ___

41. Do you get frequent muscle cramps when exercising? ___

42. Do you or someone in your family have sickle cell trait or disease? ___

43. Have you had any problems with your eyes or vision? ___

44. Have you had any eye injuries? ___

45. Do you wear glasses or contact lenses? ___

46. Do you wear protective eyewear, such as goggles or a face shield? ___

47. Do you worry about your weight? ___

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? ___

FEMALES ONLY

52. Have you ever had a menstrual period? ___

53. How old were you when you had your first menstrual period? ___

54. How many periods have you had in the last 12 months? ___

Explain “yes” answers here

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

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 ___________________________

The Athlete with Special Needs: Supplemental History Form

Date of Exam

Name

Date of birth

Sex  Age  Grade  School  Sport(s)

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthetic?</td>
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<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
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<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
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<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
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<td>10. Do you have a visual impairment?</td>
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<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
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<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
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<tr>
<td>13. Have you had autonomic dysreflexia?</td>
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<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
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<td>15. Do you have muscle spasticity?</td>
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<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
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</tbody>
</table>

Explain "yes" answers here

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
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<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Enlarged spleen</td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
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<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty controlling bladder</td>
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<tr>
<td>Numbness or tingling in arms or hands</td>
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<td></td>
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<tr>
<td>Numbness or tingling in legs or feet</td>
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<td></td>
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<tr>
<td>Weakness in arms or hands</td>
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<td></td>
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<tr>
<td>Weakness in legs or feet</td>
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<tr>
<td>Recent change in coordination</td>
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<tr>
<td>Recent change in ability to walk</td>
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<tr>
<td>Spina bifida</td>
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<tr>
<td>Latex allergy</td>
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</tbody>
</table>

Explain "yes" answers here

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

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).

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Weight</td>
<td>Male</td>
</tr>
<tr>
<td>BP</td>
<td>/</td>
<td>( )</td>
</tr>
<tr>
<td>MEDICAL</td>
<td></td>
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<tr>
<td>Appearance</td>
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<tr>
<td>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
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<td></td>
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<tr>
<td>Eyes/ears/nose/throat</td>
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<tr>
<td>• Pupils equal</td>
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<td>• Hearing</td>
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<tr>
<td>Lymph nodes</td>
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<tr>
<td>Heart</td>
<td></td>
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<tr>
<td>• Murmurs (auscultation standing, supine, +/- Valsalva)</td>
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<tr>
<td>• Location of point of maximal impulse (PMI)</td>
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<tr>
<td>Pulses</td>
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<tr>
<td>• Simultaneous femoral and radial pulses</td>
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<td></td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Genitourinary (males only)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
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<tr>
<td>• HSV, lesions suggestive of MRSA, linea corporis</td>
<td></td>
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<tr>
<td>Neurologic+c</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
Consider DEXA 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

Preparticipation Physical Evaluation

CLEARANCE FORM

Name ___________________________ Sex ☐ M ☐ F Age ______________ Date of birth ______________

☐ 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 ____________________________________________

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Name of physician (print/type) ___________________________________________ Date ______________

Address ___________________________________________ Phone _______________________

Signature of physician ____________________________________________, MD or DO

EMERGENCY INFORMATION

Allergies ____________________________________________

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Other information ____________________________________________

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