PREPARTICIPATION PHYSICAL EVALUATION - MEDICAL HISTORY FORM

NAME				D.	ATE OF BIRTH	
Sex	Age	Grade	School		Sport(s)	
Medicine	es and Allergies: P	lease list all of the prescri	iption and over-the-counter	medicines and supp	lements (herbal and nutritional) that yo	u are currently taking
Do you ha	ave any allergies? cines	□ Yes □ No If y □ Poller	ves, please identify specific	allergy below. □ Food	□ Stinging	Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

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?		
2. Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		
below: 🗆 Asthma 🔲 Anemia 🔲 Diabetes 🖾 Infections			28. Is there anyone in your family who has asthma?		
Other: 3. Have you ever spent the night in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
4. Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
 Have you ever passed out or nearly passed out DURING or AFTER exercise? 			32. Do you have any rashes, pressure sores, or other skin problems?		
6. Have you ever had discomfort, pain, tightness, or pressure in your			33. Have you had a herpes or MRSA skin infection?		
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?		
Has a doctor ever told you that you have any heart problems? If so, check all that apply:			36. Do you have a history of seizure disorder?		
\Box High blood pressure \Box A heart murmur			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?		
11. Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?		
12. Do you get more tired or short of breath more quickly than your friends			43. Have you had any problems with your eyes or vision?		
during exercise?	v		44. Have you had any eye injuries?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?		
 Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including 			46. Do you wear protective eyewear, such as goggles or a face shield?		
drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT			48. Are you trying to or has anyone recommended that you gain or lose weight?		
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of foods?		
15. Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?		
implanted defibrillator?			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?			52. Have you ever had a menstrual period?	\mid	
BONE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period?	<u> </u>	
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			54. How many periods have you had in the last 12 months? Explain "yes" answers here	<u> </u>	
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 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?			1		
23. Do you have a bone, muscle, or joint injury that bothers you?			l		
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?			l		

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

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION AND CLEARANCE FORM

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DATE OF BIRTH

EXAMINATION					
Height Weight 🗆 Male	Female				
BP / (/) Pulse Vision		L 20/ Corrected I Y I N			
MEDICAL	NORMAL	ABNORMAL FINDINGS			
Appearance	NORMAL				
 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 ^a					
Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)					
Pulses Simultaneous femoral and radial pulses					
Lungs					
Abdomen					
Genitourinary (males only) ^b					
Skin • HSV, lesions suggestive of MRSA, tinea corporis					
Neurologic °					
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 GU 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 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 eva participate in the sport(s) as outlined above. A copy of the physical exam is on record in my tions arise after the athlete has been cleared for participation, the physician may rescind th explained to the athlete (and parents/guardians).	office and can be ma	ade available to the school at the request of the parents. If condi-			

Name of physician (print/type)	Date
Address	Phone
Signature of physician	(MD, DO, or DC)

The questions and layout for both the Medical History and the Physical Examination and Clearance are from forms provided by the following: American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted for noncommercial, educational purposes with acknowledgment.