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?
   Yes No
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:
   Yes No
3. Have you ever spent the night in the hospital?
   Yes No
4. Have you ever had surgery?
   Yes No

HEART HEALTH QUESTIONS ABOUT YOU

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

MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?
   Yes No
27. Have you ever used an inhaler or taken asthma medicine?
   Yes No
28. Is there anyone in your family who has asthma?
   Yes No
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
   Yes No
30. Do you have groin pain or a painful bulge or hernia in the groin area?
   Yes No
31. Have you had infectious mononucleosis (mono) within the last month?
   Yes No
32. Do you have any rashes, pressure sores, or other skin problems?
   Yes No
33. Have you had a herpes or MRSA skin infection?
   Yes No
34. Have you ever had a head injury or concussion?
   Yes No
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
   Yes No
36. Do you have a history of seizure disorder?
   Yes No
37. Do you have headaches with exercise?
   Yes No
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
   Yes No
39. Have you ever been unable to move your arms or legs after being hit or falling?
   Yes No
40. Have you ever become ill while exercising in the heat?
   Yes No
41. Do you get frequent muscle cramps when exercising?
   Yes No
42. Do you or someone in your family have sickle cell trait or disease?
   Yes No
43. Have you had any problems with your eyes or vision?
   Yes No
44. Have you had any eye injuries?
   Yes No
45. Do you wear glasses or contact lenses?
   Yes No
46. Do you wear protective eyewear, such as goggles or a face shield?
   Yes No

FEMALES ONLY

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 ____________________________

# Preparticipation Physical Evaluation

**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>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Do you regularly use a brace, assistive device, or prosthetic?
7. Do you use any special brace or assistive device for sports?
8. Do you have any rashes, pressure sores, or any other skin problems?
9. Do you have a hearing loss? Do you use a hearing aid?
10. Do you have a visual impairment?
11. Do you use any special devices for bowel or bladder function?
12. Do you have burning or discomfort when urinating?
13. Have you had autonomic dysreflexia?
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?
15. Do you have muscle spasticity?
16. Do you have frequent seizures that cannot be controlled by medication?

Explain “yes” answers here

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Atlantoaxial instability
X-ray evaluation for atlantoaxial instability
Dislocated joints (more than one)
Easy bleeding
Enlarged spleen
Hepatitis
Osteoporosis
Difficulty controlling bowel
Difficulty controlling bladder
Numbness or tingling in arms or hands
Numbness or tingling in legs or feet
Weakness in arms or hands
Weakness in legs or feet
Recent change in coordination
Recent change in ability to walk
Spina bifida
Latex allergy

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 ____________________________


Exam must be performed by MD or DO within 6 months of start of official team activity
Name ___________________________ 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).

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 ____________________________________________________________

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

EMERGENCY INFORMATION

Allergies ____________________________________________________________

Other information ____________________________________________________________

Exam must be performed by MD or DO within 6 months of start of official team activity