## ■ 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							
Sex Age Grade Scr	nool	ol Sport(s)					
Medicines and Allergies: Please list all of the prescription and over	r-the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking			
Do you have any allergies? ☐ Yes ☐ No If yes, please ide ☐ Medicines ☐ Pollens	ntify spo		ergy below.  □ Food □ Stinging Insects				
Explain "Yes" answers below. Circle questions you don't know the ar	iswers t	0.	Parameter of the state of the s	Hersey Const.	100000000000000000000000000000000000000		
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No		
<ol> <li>Has a doctor ever denied or restricted your participation in sports for any reason?</li> </ol>			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 Other:			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		<del> </del>		
3. Have you ever spent the night in the hospital?			(males), your spleen, or any other organ?				
4. Have you ever had surgery?		, in the second	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?				
<ol><li>Have you ever passed out or nearly passed out DURING or AFTER exercise?</li></ol>			32. Do you have any rashes, pressure sores, or other skin problems?  33. Have you had a herpes or MRSA skin Infection?		-		
6. Have you ever had discomfort, pain, tightness, or pressure in your			34. Have you ever had a head injury or concussion?				
chest during exercise?  7. Does your heart ever race or skip beats (irregular beats) during exercise?	ļ		35. Have you ever had a hit or blow to the head that caused confusion,				
Has a doctor ever told you that you have any heart problems? If so,			prolonged headache, or memory problems?  36. Do you have a history of seizure disorder?		-		
check all that apply:			37. Do you have headaches with exercise?		ļ		
☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart Infection	Ĭ.		38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?				
Sawasaki disease Other:  9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG,	<u> </u>		39. Have you ever been unable to move your arms or legs after being hit				
echocardiogram)			or falling?  40. Have you ever become ill while exercising in the heat?		_		
10. Do you get lightheaded or feel more short of breath than expected 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 during exercise?			43. Have you had any problems with your eyes or vision?				
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	44. Have you had any eye injuries?  45. Do you wear glasses or contact tenses?				
13. Has any family member or relative died of heart problems or had an			46. Do you wear protective eyewear, such as goggles or a face shield?				
unexpected or unexplained sudden death before age 50 (including 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			49. Are you on a special diet or do you avoid certain types of foods?				
polymorphic ventricular tachycardia?			50. Have you ever had an eating disorder?				
15. Does anyone in your family have a heart problem, pacemaker, or 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				
setzures, or near drowning?			52. Have you ever had a menstrual period?		<u> </u>		
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?			LAPIANI YOS ANSWOOD NOIC				
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		1				
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?		L	]				
I hereby state that, to the best of my knowledge, my answers to							
Signature of athlete Signature	of parent/	guardian _	Date				

## PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

2. Contact reviewing questions on conditionate and symplems (questions 5-1-4).    Experiment   Weight	Do you ever feel safe at y     Do you ever feel safe     Do you feel safe at y     Have you ever tried (     During the past 30 d     Do you drink alcohol     Have you ever taken     Have you ever taken	DERS estions on more sensitive issues l out or under a lot of pressure? l, hopeless, depressed, or anxious? rour home or residence? lays, did you use chewing tobacco, snuff, or dip? l or use any other drugs? anabolic steroids or used any other performand any supplements to help you gain or lose weigh belt, use a helmet, and use condoms?	e supplement?	nance?			
Height   Weight   Pairs   Pair			5–14),				
Price						1	
MORMAL PRODUCES  Marker signates (Pophosocilosts, high-serbed positie, partities executation, strechnocacity)s, arm span > height, theyerbasky, myopis, M/P, ear ic insulficiency)  Executory focus of the partition of the partiti	· -	·					
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Heart*	Pupils equal						
Morants (auscalitation standing, supline, M-Valelway)     Location of policy of maximal impulse (PM)     Falses     Simultaneous femoral and radial pulses     Lungs     Abdomen     Genitourinary (makes only)*     Skin     HSV, lasions suggestive of MISSA, tinea corporis     Neurologis*     Neurologis*     Neurologis*     Neurologis*     Neurologis*     Skin     Stock     Substantial (MISSA)     Skin	Lymph nodes						
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	Name of physician /print#	tunel				Data	
MUNICIA							
Signature of physician, N  © 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopae			V///E/	***************************************			

\_\_\_\_\_ Date of birth \_\_\_\_\_

## Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print)								
As a parent or legal guardian of the above named student-athlete. I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.								
Signature of Athlete	Date							
Signature of Parent/Guardian								
	Date							
Personal Physician:								
Emergency Contact:								
Name:								
Relationship:								
Phone number(s):								