

# PREPARTICIPATION PHYSICAL EVALUATION | Ohio High School Athletic Association – 2023-2024

# **HISTORY FORM**

Note: Complete and sign this form (with your paren	ts if younger than 18) before your appo	intment.
Name:	Date of birth:	Grade in School:
Date of examination:	Sport(s):	
Sex assigned at birth (F, M, or intersex):	How do you identify your ge	nder? (F, M, or other):
List past and current medical conditions:		
Have you ever had surgery? If yes, list all past surg	ical procedures:	
Medicines and supplements: List all current prescri	ptions, over-the-counter medicines, and	supplements (herbal and nutritional):
Do you have any allergies? If yes, please list all your	allergies (i.e., medicines, pollens, food, s	tinging insects):
Patient Health Questionnaire Version 4 (PHQ-4)  Over the last 2 weeks, how often have you been be	nothered by any of the following proble	ms2 (Circle response)
Over the last 2 weeks, now often have you been b		Over half the days Nearly every day

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
Do you have any concerns that you would like to discuss with your provider?		
Has a provider ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU		
(CONTINUED)	Yes	No
Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	Nc
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE & JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had, or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here:				



## PREPARTICIPATION PHYSICAL EVALUATION | Ohio High School Athletic Association - 2023 - 24

### ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:	Date of birth:	
1. Type of disability:	The state of the s	
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily ac		
7. Do you use any special brace or assistive device for sports?	Annual Control of the	<u> </u>
8. Do you have any rashes, pressure sores, or other skin problems?		<del> </del>
9. Do you have a hearing loss? Do you use a hearing aid?		<b>†</b>
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 as having a heat-related (hyperthermia) or cold-re	lated (hypothermia) illness?	
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		
Explain "Yes" answers here:		<u> </u>
Please indicate whether you have ever had any of the following conditions:	Yes	Nio
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or 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 questions	s on this form are complete and correct	Na Alvino
Signature of athlete:		
Signature of parent or guardian:		410
Date:		
Dutc		

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#### PREPARTICIPATION PHYSICAL EVALUATION - Ohio High School Athletic Association - 2023-2024

#### PHYSICAL EXAMINATION FORM

ame:	Date of Birth:	Grade in School: ————
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#### 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, e-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-enhancing 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 q	uestions on cardiova	scular symptoms (Q4–Q13	of History Forn	n).	
EXAMINATION					
Height:	Weight:				
BP: / ( /	) Pulse:	Vision: R 20/	L 20/	Corrected: 0	□Y □N
MEDICAL				NOR	MAL ABNORMAL FINDINGS
Appearance					
<ul> <li>Marfan stigmata (kypho myopia, mitral valve pro</li> </ul>		alate, pectus excavatum, aracl c insufficiency)	nnodactyly, hyperl	axity,	
Eyes, ears, nose, and throat					
Pupils equal					
Hearing					
Lymph nodes					
Heart <sup>a</sup>					
Murmurs (auscultation st	tanding, auscultation su	pine, and ± Valsalva maneuver	}		
Lungs					
Abdomen					
Skin	M 1:		anna munava (NADCA		
<ul> <li>Herpes simplex virus (HS\ tinea corporis</li> </ul>	v), lesions suggestive of	methicillin-resistant Staphyloco	ccus aureus (IVIRSA	(), or	
Neurological	**************************************				
MUSCULOSKELETAL				NOR	MAL ABNORMAL FINDINGS
Neck					
Back					
Shoulder and arm					
Elbow and forearm					
Wrist, hand, and fingers					
Hip and thigh					
Knee					
Leg and ankle					
Foot and toes					
Functional					
Double-leg squat test, sin	ngle-leg squat test, and	box drop or step drop test			
<ul> <li>Consider electrocardiograph nation of those.</li> </ul>	ıy (ECG), echocardiogra	phy, referral to a cardiologist (	or abnormal card	iac history or ex	amination findings, or a combi-
	onal (print or type):				Date:
Address:					
Signature of health care profe	essional:				, MD, DO, DC, NP, or PA

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#### PREPARTICIPATION PHYSICAL EVALUATION | OHIO HIGH SCHOOL ATHLETIC ASSOCIATION - 2023-2024

# MEDICAL ELIGIBILITY FORM Date of Birth: Grade in School: — Name: \_ ☐ Medically eligible for all sports without restriction □ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ☐ Medically eligible for certain sports □ Not medically eligible pending further evaluation ☐ Not medically eligible for any sports Recommendations: I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians). Name of health care professional (print or type): \_\_\_\_\_\_ Date of Exam:\_\_\_\_\_ Address: \_\_\_\_\_\_ Phone: \_\_\_\_\_ , MD, DO, DC, NP, or PA Signature of health care professional: SHARED EMERGENCY INFORMATION Other information: \_\_\_\_ Emergency contacts: \_\_\_\_

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