

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: The student and parent must fill out this form prior to seeing the provider. The provider should keep a copy of this form in the chart.)

NAME: _____ Date of Birth _____

Sex _____ Age _____ Grade _____ School/Sport _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal/nutritional) that you are currently taking.

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Do you have any allergies? Yes _____ No _____ If yes, please identify specific allergy below.

Do you currently use an EpiPen? Yes _____ No _____ Medicines _____ Pollen _____ Food _____ Stinging Insects _____

Explain "Yes" answers below. **Please circle questions you do not know the answers to.**

YES NO

GENERAL QUESTIONS	YES	NO		YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?			27. Do you have groin pain or a painful bulge or hernia in the groin area?		
2. Do you have any ongoing medical conditions? If so, please identify Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Infections <input type="checkbox"/> Diabetes <input type="checkbox"/>			28. Do you have any rashes, pressure sores, or other skin problems?		
3. Have you ever spent the night in the hospital?			29. Have you ever had a head injury or concussion(s)? If yes, please provide date(s): _____, _____, _____.		
4. Have you ever had surgery?			30. Do you have a history of seizure disorder?		
HEART HEALTH QUESTIONS ABOUT YOU	YES	NO	31. Have you had a herpes or MRSA skin infection?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			32. Do you have headaches with exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			33. Have you ever had numbness, tingling, or weakness in your arms, or legs after being hit or falling?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			34. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High BP <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Infection <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease			35. Have you ever been unable to move your arms or legs after being hit or falling?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			36. 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?			37. Do you get frequent muscle cramps when exercising?		
11. Have you ever had an unexplained seizure?			38. Have you had any problems with your eyes or vision?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			39. Have you had any eye injuries?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	YES	NO	40. Do you wear glasses or contact lenses?		
13. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?			41. Do you wear protective eyewear, such as goggles or a face shield?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Are you trying or has anyone recommended that you gain or lose weight?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Are you on a special diet or do you avoid certain types of foods?		
BONE AND JOINT QUESTIONS	YES	NO	44. Have you ever had an eating disorder?		
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you have any concerns that you would like to discuss with a doctor?		
17. Have you ever had any broken or fractured or dislocated joints?			46. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?					
19. Have you ever had a stress fracture?			FEMALES ONLY	YES	NO
20. Do you regularly use a brace, orthotics, or other assistive device?			47. Have you ever had a menstrual period?		
21. Do you have a bone, muscle, or joint injury that bothers you?			48. How old were you when you had your first menstrual period?		
22. Do any of your joints become painful, swollen, feel warm, or look red?			49. How many periods have you had in the last 12 months?		
MEDICAL QUESTIONS	YES	NO	Explain "yes" answers here:		
23. Do you cough, wheeze, or have difficulty breathing during or after exercises?					
24. Have you ever used an inhaler or taken asthma medicine?					
25. Is there anyone in your family who has asthma?					
26. Do you currently use an asthma Rescue inhaler?					

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

Revised 6/2019

Signature of Athlete _____ Date: _____

Signature of Parent/Guardian _____ Date: _____

PRE-PARTICIPATION PHYSICAL EVALUATION for INTERSCHOLASTIC ATHLETICS

This page to be completed by physician/nurse practitioner/physician assistant

STUDENT NAME: _____ Date of Birth: _____
 HEIGHT: _____ WEIGHT: _____ % BODY FAT (optional) _____ PULSE: _____ BP: _____
 VISION: R 20/____ L 20/____ CORRECTED? Y N PUPILS: EQUAL____ UNEQUAL____

	NORMAL	ABNORMAL FINDING	INITIALS *
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE:

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____
- NOT cleared for [Sport(s)]: _____ Reason: _____

Recommendation: _____

Name of Physician/Nurse Practitioner/Physician's Assistant _____ Date: _____

Address: _____ Print or Type
Phone: _____

Signature of Physician/Nurse Practitioner/Physician Assistant _____

I hereby certify that I have reviewed the student pre-participation History Form and performed a comprehensive pre-participation physical evaluation of the herein named student.

***DATE OF EXAM:** _____

REVISED 6/2019

PHYSICIANS STAMP: