PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents	if younger than	18) before your ap	pointment.	
Name:			ate of birth:	
Date of examination:	Sport(s)			
Sex assigned at birth (F, M, or intersex):	How do	you identify your	gender? (F, M, or other):
List past and current medical conditions.				
Have you ever had surgery? If yes, list all past surgica	procedures.			
Medicines and supplements: List all current prescripti	ons, over-the-co	unter medicines, a	nd supplements (herba	and nutritional).
Do you have any allergies? If yes, please list all your	allergies (ie, me	dicines, pollens, fo	ood, stinging insects).	
Patient Health Questionnaire Version 4 (PHQ-4)				
Over the last 2 weeks, how often have you been both				
- h	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
(A sum of ≥3 is considered positive on either su	bscale [question	s 1 and 2, or ques	tions 3 and 4] for scree	ening purposes.)

	lain "Yes" answers at the end of this form. le questions if you don't know the answer.	Yes	No
1.	Do you have any concerns that you would like to discuss with your provider?		
2.	Has a provider ever denied or restricted your participation in sports for any reason?		
3.	Do you have any ongoing medical issues or recent illness?		
HEA	RT HEALTH QUESTIONS ABOUT YOU	Yes	No
4.	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?		
6.	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?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

(CC	PNTINUED)	Yes	No
9.	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10.	Have you ever had a seizure?		
HEA	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
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?		

BON	IE AND 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?		
MED	ICAL 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 <i>Staphylococcus aureus</i> (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 prob- lems with your eyes or vision?		

MED	ICAL 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?		
FEM	ALES 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?		
	How many periods have you had in the past 12		

Piani 100 1	answers here		

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

Signature of athlete: ______
Signature of parent or guardian: ______
Date: ____

© 2019 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 to reprint for noncommercial, educational purposes with acknowledgment.

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

PH	YSIC	IAN REI	VINDE	RS										
					stion	s on more-se	oncitivo in							
	•	Do you	feel str	essed	out o	r under a la	ot of press	ives.						
	•	Do you	ever fe	el sad	. hon	eless, depre	accod or c	nevious?						
	•	Do you	feel sa	fe at y	our h	ome or resi	idence?	111110025						
	•	Have yo	u ever	tried o	igar	ettes, e-ciaa	rettes, che	wing tobacco, snul	f or dina					
	•	During 1	he pas	t 30 d	ays,	did you use	chewina t	obacco, snuff, or d	ins					
	•	Do you	drink a	Icohol	or u	se any other	r drugs?							
	•	Have yo	u ever	taken	anak	olic steroids	s or used o	any other performa	nce-enhanc	ina supplem	entS			
	-	i iuve yo	u ever	raken :	any :	supplements	s to help vo	ou gain or lose wei	ght or impro	ve vour ner	formance	s		
_	•	DO YOU .	wear a	sear p	ieir, u	ise a heimet	t, and use	condoms?				•		
2.	Con	isider re	viewing	g quest	ions	on cardiove	ascular syn	nptoms (Q4-Q13	of History Fo	orm).				
EX	(AMII	NOITAN	1000	The same	RA.			R. J. S. L.	100 PM	BR SER AS	C. Carrie	Park.	45	A Transport
He	ight:				1	Weight:			75 10 10 10			200		
BP:		/	(1)	Pulse:		Vision: R 20/		L 20/	Cama	-tJ.	ΠY	
M	EDIC/	AL.	120	119			TO STAN	HISTORY (CO)	189120	L 20/	Corre	_		
Ap	peard	nce		_								INC	RMAL	ABNORMAL FINDING
1.	Marf	an stign	iata (ky	/phose	olios	is, high-arcl	hed palate	e, pectus excavatum	arachnod	actide become	استند			
	myop	oia, mitr	al valve	prolo	pse	[MVP], and	aortic insu	officiency)	i, araciiilogi	aciyiy, nyper	iaxiry,	1		
Eye	s, ea	rs, nose,	and th	roat								+-		
1.	Pupil:	s equal												
1.	Hear	ing												
Lym	ph no	odes												
Hec					_						_	_		
		nurs (aus	cultatio	on stan	dina	auscultatio	on supine	and ± Valsalva ma						
Lung	as				9	, addeditant	m sopme,	ana ± vaisaiva ma	neuver			_		
_	lomer	1										_		
Skin	_				_							_		
		es simple	y virus	/HSVI	lori	one cuasacti		hicillin-resistant Sta	, ,					
l +	inea	corporis	,,,,,,,	(1.101)	, 1031	ons suggesi	ive of fileti	ilicillin-resistant Sta	phylococcus	aureus (MR	SA), or			
	rolog						_							
THE RESERVE TO THE PERSON NAMED IN	100	OSKELE	AL	75	NIII	B 5 107	S. 150	S. C. C. C. C. C. C.	and the second					
Nec				and the same	Part .					to their		NOF	MAL	ABNORMAL FINDINGS
Back					_									
		and arm		-	_									
		d forear	_											
_					_									
		nd, and	ingers											
	and th	nigh												
Knee														
	and a													
Foot														
Funct													-	
• D	ouble	-leg squ	at test,	single	-leg :	squat test, a	ind box dr	op or step drop tesi	}					
Consi	ider e	electroca	rdiogra	aphy (I	ECG	, echocardi	oaraphy, i	referral to a cardiol	agist for ab	normal card	سماما م			tion findings, or a combi-
														tion tindings, or a combi-
Vame	of he	alth care	profe	ssional	(pri	nt or type):							Dada	
4aares	ss:											ne:		
Signatu	ure of	health d	аге рг	ofessio	nal:									AID DO AID D

Date of birth:

, MD, DO, NP, or PA

© 2019 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 to reprint for noncommercial, educational purposes with acknowledgment.

Oconec Pediatrics

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM Name: _ Date of birth: ☐ 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 $\ \square$ 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 are 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 chime calculate in squardians). Date: _____ Seneca, SC 29678 Address: ___ ______ Phone: _____ Signature of health care professional: _____, MD, DO, NP, or PA SHARED EMERGENCY INFORMATION Allergies: Medications: Other information: Emergency contacts:

^{© 2019} 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 to reprint for noncommercial, educational purposes with acknowledgment.

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-a mission for his/her participation in athletic events and the ph for that participation. I understand that this is simply a screen and not a substitute for regular health care. I also grant perm ment deemed necessary for a condition arising during particle events, including medical or surgical treatment that is recommedical doctor. I grant permission to nurses, trainers and comphysicians or those under their direction who are part of athlevention and treatment, to have access to necessary medical know that the risk of injury to my child/ward comes with particle and during travel to and from play and practice. I have had the understand the risk of injury during participation in sports throw written information or by some other means. My signature into the best of my knowledge, my answers to the above question and correct. I understand that the data acquired during these may be used for research purposes.	ysical evaluation for ipation of mended baches as vertical injury information in the opportunity ough meeticates that the control of the cont	aluation lation treat- these by a well as pre- on. I sports inity to tings
Signature of Athlete	Date:	
Signature of Parent/Guardian	Date:	10 31 31

		ı	