

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this torm (with your parer Name:	,			te of birth:								
		Sport(s):										
Sex: M/F												
List past and current medical conditions.												
Have you ever had surgery? If yes, list all past surg	gical proced	ures										
Medicines and supplements: List all current prescr	riptions, ove	r-the-cour	ter medicines, an	nd supplements (herbal and n	utritiona	——— d).						
Do you have any allergies? If yes, please list all ye	our allergies	s (ie, med	cines, pollens, fo	od, stinging insects).								
Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been been been been been been been bee		any of th	1000	ems? (check box next to appro								
Feeling nervous, anxious, or on edge					.,, 3.3., □3	aay						
Not being able to stop or control worrying		0	1	□ 2	□3							
Little interest or pleasure in doing things		0		□ 2	3							
Feeling down, depressed, or hopeless		0	□ 1	2	□3							
(A sum of \geq 3 is considered positive on either	er subscale [questions	1 and 2, or ques	tions 3 and 4] for screening	purposes	5.)						
GENERAL QUESTIONS	建工程的		IEART HEAITH OUE	ESTIONS ABOUT YOU								
(Explain "Yes" answers at the end of this form.		mark the second	CONTINUED)	SHONS ABOUT TOU	Yes	No						
Circle questions if you don't know the answer.)	Yes No			nt-headed or feel shorter of brea								
Do you have any concerns that you would like to discuss with your provider?] L		ds during exercise?								
Has a provider ever denied or restricted your participation in sports for any reason?		i L	0. Have you ever	had a seizure?								
Do you have any ongoing medical issues or		_		ESTIONS ABOUT YOUR FAMILY	Yes	No						
recent illness?				member or relative died of hea								
HEART HEALTH QUESTIONS ABOUT YOU	Yes No			nd an unexpected or unexplained pefore age 35 years (including	' ┌─	1 [
Have you ever passed out or nearly passed out during or after exercise?		J L		nexplained car crash)?		<u> </u>						
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			problem such o	n your family have a genetic hec as hypertrophic cardiomyopathy n syndrome, arrhythmogenic rigi								
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?]	ventricular care syndrome (LQ)	diomyopathy (ARVC), long QT TS), short QT syndrome (SQTS),								
7. Has a doctor ever told you that you have any heart problems?				ome, or catecholaminergic poly cular tachycardia (CPVT)?								
 Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 				your family had a pacemaker o defibrillator before age 35?	r	௱						



BONE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED)	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?			25. Do you worry about your weight? 26. Are you trying to or has anyone recommended that you gain or lose weight?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?		
MEDICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMALES ONLY	Yes	No
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			29. Have you ever had a menstrual period? 30. How old were you when you had your first menstrual period?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			31. When was your most recent menstrual period?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			32. How many periods have you had in the past 12 months? Explain "Yes" answers here.		
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?					
I hereby state that, to the best of my kno and correct. Signature of athlete: Signature of parent or guardian: Date:			y answers to the questions on this form are c	omple	e te
2019 American Academy of Family Physicians American Academy	domy of F	Podiatrica	American College of Sports Medicine, American Medical Society for S	ports Mr	

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PHYSICAL EXAMINATION FORM

Name:	Date of birth:
PHYSICIAN REMINDERS	
 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. Cor	nsider re	viewin	ig que	stions	on cardiovascul	lar symptoms (Q4-	Q13 of Hist	ory Form).							
EXAMI	NATION					Carlos Attended						TO FEE		12	
Height:					Weight:										
BP:	/	(/)	Pulse:	Vision:	R 20/	L 20/	Corre	cted:		Υ	JΝ	-	
MEDIC	AL									N	ORM	AL	ABNOR	MAL FIN	IDINGS
	fan stig				sis, high-arched [MVP], and aor	palate, pectus exc tic insufficiency)	avatum, ara	chnodactyly, hyp	perlaxity,						
Eyes, edPupiHea	ls equal		throat			٠									
Lymph r	nodes														
Heart										1					
	murs (a	usculta	tion st	andir	ng, auscultation s	supine, and ± Valso	ılva maneuv	rer)		Ļļ		_			¥
Lungs										Ш		_			
Abdome	en									_		1			
100	oes simp a corpor		us (HS	5V), le	esions suggestive	of methicillin-resis	tant Staphyl	ococcus aureus	(MRSA), or]			
Neurolo	gical														
MUSCL	JLOSKE	ETAL					新教书			N	ORM	AL	ABNOR	MAL FIN	IDINGS
Neck															
Back							r.								
Shoulde	r and a	rm													
Elbow a	ınd fore	arm													
Wrist, h	and, an	d finge	ers												
Hip and	l thigh														
Knee							\								
Leg and	ankle														
Foot and	d toes														
Function Doul		quat t	est, sir	ngle-le	eg squat test, and	d box drop or step	drop test]			
nation of	those.			-2.	•	graphy, referral to	50								a combi-
Address:					al:	and the second s		avast.	P	hone	:				

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■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELICIDILITY EODM

Name:	Date of birth:	
Medically eligible for all sports without restriction	Date of birin.	
Medically eligible for all sports without restriction with recommendat	tions for further evaluation or treatment of	
Medically eligible for certain sports		
□ Not medically eligible pending further evaluation		_
☐ Not medically eligible for any sports		
Recommendations:		-
2		
I have examined the student named on this form and completed apparent clinical contraindications to practice and can participate examination findings are on record in my office and can be ma arise after the athlete has been cleared for participation, the phy and the potential consequences are completely explained to the	ate in the sport(s) as outlined on this form. A copy o ade available to the school at the request of the pare sysician may rescind the medical eligibility until the p	of the physical ents. If conditions
Name of health care professional (print or type):	Date:	
Address:	Phone:	
Signature of health care professional:		_, MD, DO, NP, or PA
SHARED EMERGENCY INFORMATION		
Allergies:		_
		_
Medications:		
		_
Other information:		
		_
Emergency contacts:		
		_
		_

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