**HISTORY FORM**

(Use: This form is to be filled out by patient or parent/guardian (if a minor) prior to seeing the physician)

Date of Exam / / Name: (Last) (First) DOB / /

Sex assigned at birth (M/F or intersex) _________ How do you identify your gender (M/F or other): ___________

Club Sport_________ Expected Graduation Date (Month) ______/______ (Year)__________

**Medical and Allergies:** Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_________________________ ________________________

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

□ Medicines □ Pollens □ Food □ Stinging Insects

Explain “Yes” answers below. Circle questions you don’t know the answers to.

**GENERAL QUESTIONS**

1. Has a doctor ever denied or restricted your participation in sports or any other activity because of your gender?__________

2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Anemia □ Diabetes □ Infections Other:

3. Have you ever spent the night in the hospital?__________

4. Have you ever had surgery?__________

**HEART HEALTH QUESTIONS ABOUT YOU**

5. Have you ever passed out or nearly passed out during or after exercise?__________

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?__________

7. Does your heart ever race or skip beats (irregular beats) during exercise?__________

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki Disease Other:

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)__________

10. Do you get lightheaded or feel short of breath or feel pressure in your chest during exercise?__________

11. Have you ever had an unexplained seizure?__________

12. Do you get more tired or short of breath more quickly than your friends during exercise?__________

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexpected car accident, or sudden infant death syndrome)?__________

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?__________

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?__________

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?__________

**BONE AND JOINT QUESTIONS**

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?__________

18. Have you ever had any broken or fractured bones or dislocated joints?__________

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?__________

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?__________

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

Signature of athlete__________ Signature of parent/guardian__________ Date__________


HE5003

9.2661.0410
## Preparticipation Physical Evaluation
### PHYSICAL EXAMINATION FORM

Name ___________________________ DOB: ______________________

**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, 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 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 questions on cardiovascular symptoms (questions 5–14).

### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
<th>BP</th>
<th>( )</th>
<th>Pulse</th>
<th>Vision R 20/</th>
<th>L 20/</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

### MEDICAL

- Appearance
  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

- Eyes/ears/nose/throat
  - Pupils equal
  - Hearing

- Lymph nodes

- Heart
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)

- Pulses
  - Simultaneous femoral and radial pulses

- Lungs

- Abdomen

- Genitourinary (males only)

- Skin
  - HSV, lesions suggestive of MRSA, sinea corporis

- Neurologic

### MUSCULOSKELETAL

- Neck

- Back

- Shoulder/arm

- Elbow/forearm

- Wrist/hand/fingers

- Hip/thigh

- Knee

- Leg/ankle

- Foot/toes

- Functional
  - Duck-walk, single leg hop

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*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider GU exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

☐ Not cleared

  ☐ Pending further evaluation

  ☐ For any sports

  ☐ For certain sports

Reason/Recommendations ________________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________________________ Date ____________
Address ____________________________________________ Phone ____________________

Signature of physician ___________________________ MD or DO