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.

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.***

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 medicals conditions? If so, please identify **Asthma** ☐ **Anemia** ☐ **Infections** ☐ **Diabetes** ☐				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: ☐ High BP ☐ Heart Murmer ☐ Heart Infection ☐ High Cholesterol ☐ Kawasaki Disease				35. Have you ever been unable to move your arms or legs after being hit or falling?		
				36. Have you ever become ill while exercising in the heat?		
				37. Do you get frequent muscle cramps when exercising?		
				38. Have you had any problems with your eyes or vision?		
				39. Have you had any eye injuries?		
				40. Do you wear glasses or contact lenses?		
9. Has a doctor ever ordered a test for your heart ? (For example, ECG/EKG, echocardiogram)				41. Do you wear protective eyewear, such as goggles or a face shield?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?				42 Are you trying or has anyone recommended that you gain or lose weight?		
11. Have you ever had an unexplained seizure?				43. Are you on a special diet or do you avoid certain types of foods?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?				44. Have you ever had an eating disorder?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**				
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)?				45. Do you have any concerns that you would like to discuss with a doctor?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				46. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?						
BONE AND JOINT QUESTIONS	**YES**	**NO**				
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?						
17. Have you ever had any broken or fractured or dislocated joints?				**FEMALES ONLY**	**YES**	**NO**
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				47. Have you ever had a menstrual period?		
19. Have you ever had a stress fracture?				48. How old were you when you had your first menstrual period?		
20. Do you regularly use a brace, orthotics, or other assistive device?				49. How many periods have you had in the last 12 months?		
21. Do you have a bone, muscle, or joint injury that bothers you?				**Explain "yes" answers here:**		
22. Do any of your joints become painful, swollen, feel warm, or look red?						
MEDICAL QUESTIONS	**YES**	**NO**				
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:__________

Print or Type

Address: ______________________________ 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: ____________________**

PHYSICIANS STAMP:

REVISED 6/2020