History Form

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam __________________________ Date of birth __________________________

Sex ______ Age ______ Grade ______ Organization or Affiliation ______ Sport(s) ______

Medicines and Allergies: Please list all of 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 for any reason?
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 more short of breath than expected 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, unexplained 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 tendons 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 x-rays 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 student __________________________ Date ________________

# Preparticipation Physical Evaluation

## Physical Examination Form

### Name __________________________  Date of birth __________________________

### Address __________________________  Phone __________________________

### Name of physician (print/type) __________________________  Date __________________________

### Address __________________________  Phone __________________________

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### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Pulse</td>
<td>Vision R 20/</td>
<td>L 20/</td>
<td>Corrected</td>
</tr>
</tbody>
</table>

### MEDICAL

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>□ Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperfaxy, myopia, MVP, aortic insufficiency)</td>
<td></td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td>□ Pupils equal</td>
<td></td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>□ Murmurs (auscultation standing, supine, +/- Valsalva)</td>
<td></td>
</tr>
<tr>
<td>Pulsates</td>
<td>□ Simultaneous femoral and radical pulses</td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Genitourinary (males only) | *
| Skin | □ HSV, lesions suggestive of MRSA, tinea corporis |
| Neurologic | *

### Musculoskeletal

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*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.

### Clearance

- □ Cleared for participation in __________________________________________
- □ Recommendations for further evaluation or treatment. Reason __________________________________________

- □ Not cleared

### Medical History

- Have you ever taken anabolic steroids or used any other performance supplement? Yes | No
- Have you ever taken any supplements to help you gain or lose weight or improve your performance? Yes | No
- Do you drink alcohol or use any other drugs? Yes | No
- Do you feel stressed out or under a lot of pressure? Yes | No
- Do you feel safe at your home or residence? Yes | No
- Do you ever feel sad, hopeless, depressed, or anxious? Yes | No
- During the past 30 days, did you use chewing tobacco, snuff, or dip? Yes | No

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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