## PREPARTICIPATION PHYSICAL EVALUATION 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.)

Name			Date of birth		
x Age Grade School		Sport(s)			
Medicines and Allergies: Please list all of the prescription and over	-the-co	unter m	nedicines and supplements (herbal and nutritional) that you are currently	/ taking	
Do you have any allergies? ☐ Yes ☐ No If yes, please ide ☐ Medicines ☐ Pollens	ntify sp	ecific al	lergy below. □ Food □ Stinging Insects	-	
explain "Yes" answers below. Circle questions you don't know the an	swers 1	n.			
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	1
Has a doctor ever denied or restricted your participation in sports for any reason?			Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		
below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:			28. Is there anyone in your family who has asthma?		
Have you ever spent the night in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
4. Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?	1	$\vdash$
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
5. Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?		
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Have you ever had a head injury or concussion?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			35. 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,			36. Do you have a history of seizure disorder?	-	-
check all that apply:  High blood pressure			37. Do you have headaches with exercise?		$\vdash$
High cholesterol A heart infection  Kawasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		Г
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?		
10. Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat?		
during exercise?  11. Have you ever had an unexplained seizure?			41. Do you get frequent muscle cramps when exercising?		
Do you get more tired or short of breath more quickly than your friends			42. Do you or someone in your family have sickle cell trait or disease?  43. Have you had any problems with your eyes or vision?	-	-
during exercise?			44. Have you had any eye injuries?		$\vdash$
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?	-	-
<ol> <li>Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including</li> </ol>			46. Do you wear protective eyewear, such as goggles or a face shield?		
drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		
<ol> <li>Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT</li> </ol>			48. Are you trying to or has anyone recommended that you gain or lose weight?		
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of foods?		
15. Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?		
implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?  FEMALES ONLY		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			52. Have you ever had a menstrual period?		-
BONE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			54. How many periods have you had in the last 12 months?  Explain "ves" answers here		
18. Have you ever had any broken or fractured bones or dislocated joints?			evhiani les ansmeis neie		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections therapy a brace a cast or crutches?					
injections, therapy, a brace, a cast, or crutches?  20. Have you ever had a stress fracture?					
Have you ever been told that you have or have you had an x-ray for neck instability or attantoaxial 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?					

## PREPARTICIPATION PHYSICAL EVALUATION 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, chewing tobacco, snuff, or dip?		
<ul> <li>During the past 30 days, did you use chewing tobacco, snuff, or dip?</li> <li>Do you drink alcohol or use any other drugs?</li> <li>Have you ever taken anabolic steroids or used any other performance supplement?</li> <li>Have you ever taken any supplements to help you gain or lose weight or improve your perfor</li> <li>Do you wear a seat belt, use a helmet, and use condoms?</li> <li>Consider reviewing questions on cardiovascular symptoms (questions 5–14).</li> </ul>	mance?	
EXAMINATION		
Height Weight □ Male	☐ Female	
BP / ( / ) Pulse Vision	R 20/	L 20/ Corrected D Y D N
VEDICAL	NORMAL	ABNORMAL FINDINGS
<ul> <li>Appearance</li> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>		
Eyes/ears/nose/throat Pupils equal Bearing		
ymph nodes	1	
Murmurs (auscultation standing, supine, +/- Valsalva)     Location of point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
ungs		
Notation	<del> </del>	
Genitourinary (males only) <sup>b</sup> Skin	<del> </del>	-
HSV, lesions suggestive of MRSA, tinea corporis		
WUSCULOSKELETAL		
leck		
Back		
Shoulder/arm		
Ilbow/forearm		
Vrist/hand/fingers lip/thigh	<del> </del>	1
(nee		
.eg/ankle		
oot/toes		
Functional  Duck-walk, single leg hop		
Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  Consider 6U 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	nent for	
Not cleared		
☐ Pending further evaluation		
☐ For any sports		
☐ For certain sports		
Reason		
ecommendations		
have examined the above-named student and completed the preparticipation physical evaluation in the sport(s) as outlined above. A copy of the physical exam is on record in my ions arise after the athlete has been cleared for participation, the physician may rescind the explained to the athlete (and parents/guardians).  Name of physician (print/type)  Address  1409  CHATTANOOGA AVE. DAL	r office and can be ma ne clearance until the p	ade available to the school at the request of the parents. If condi-
ddress 1907 CHATTANOOGA ATE. DAL	- OIV   GIT	Phone 100 218 JS A

## ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

		Sex 🗆 M 🗆 F Age	Date of birth
☐ Cleared for	all sports without restriction		
☐ Cleared fo	r all sports without restriction with recon	nmendations for further evaluation or treatment for	·
□ Not clearer	1		
	Pending further evaluation		
	For any sports		
Recommendat			
-			
and can be the the	made available to the school at th	ticipate in the sport(s) as outlined above. A copy of the p ne request of the parents. If conditions arise after the ath I the problem is resolved and the potential consequence	lete has been cleared for participation,
Name of physi	cian (print/type)		Date
14 June 14	AG MILATTANIANCI	A AVE DALION GA BOTON	
Address	101 CHAITAMOOGI	HIE. DALION, OH SUIZU	Phone <b>706</b> 278 6373
		NE. DALION, ON SO120	
Signature of pl	nysician		
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Signature of pl	nysician		
Signature of pl	nysician		
Signature of pl	CY INFORMATION		
Signature of pi	CY INFORMATION		
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