■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents i	if younger than 18) before your appointment.
Name:	Date of birth:
Date of examination:	Sport(s):
Sex assigned at birth (F, M, or intersex): How do you identify your gender? (F, M, or other): List past and current medical conditions Have you ever had surgery? If yes, list all past surgical procedures	
List past and current medical conditions.	
Have you ever had surgery? If yes, list all past surgion	cal procedures
Medicines and supplements: List all current prescrip	otions, over-the-counter medicines, and supplements (herbal and nutritional).
Do you have any allergies? If yes, please list all your a	allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been b	oothered by any of	the following prob	olems? (Circle response.)
	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
(A sum of ≥3 is considered positive on either	r subscale [questio	ns 1 and 2, or que	stions 3 and 4] for scree	ening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	0	
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
 Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	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?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
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?	O	

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

	100 1		
- 10			
	11		
	70		
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21	n		

COVID-19

- A current physical MUST be on file. CHSAA recommends this PPE form.
 - COVID-19 specific questions should be included in the physical screening to include:
 - 1. Have you tested positive for COVID-19?
 - 2. Have you had any known exposure to a COVID-19 positive individual?
 - 3. Have you been tested for COVID-19?
 - 4. Have you had any new onset of cough or shortness of breath?
 - 5. Have you experienced any recent temperature greater than 100.3°
 - The most recent medical evidence recommends consideration of cardiac testing if a student athlete has
 previously tested positive for COVID-19. This should be discussed with the team physician on a case-by-case
 basis.

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

Signature of athlete:	
Signature of parent or guardian:	
Date:	_
	~

PREPARTICIPATION PHYSICAL EVALUATION

DUVCICAL EVALADATION CODAL

Name:	N.			
PHYSICIAN REMINDERS		D	ate of birth:	
 Consider additional questions on more-sens Do you feel stressed out or under a lot o Do you ever feel sad, hopeless, depress Do you feel safe at your home or reside Have you ever tried cigarettes, e-cigare During the past 30 days, did you use of Do you drink alcohol or use any other of Have you ever taken anabolic steroids Have you ever taken any supplements to Do you wear a seat belt, use a helmet, Consider reviewing questions on cardiovas 	f pressure? sed, or anxious? ence? ettes, chewing tobacco, snuff, or dip newing tobacco, snuff, or dip? drugs? or used any other performance-enh to help you gain or lose weight or in and use condoms?	ancing suppleme nprove your perf		
EXAMINATION				
Height: Weight:				
BP: / (/) Pulse:	Vision: R 20/	L 20/	Corrected: □ Y	□ N
MEDICAL			NORMAL	ABNORMAL FINDINGS
 Appearance Marfan stigmata (kyphoscoliosis, high-arch myopia, mitral valve prolapse [MVP], and a 	311 201	nodactyly, hyper	laxity,	
Eyes, ears, nose, and throat				
Pupils equalHearing				
, ,				-
Lymph nodes Heart ^a				
Murmurs (auscultation standing, auscultation)	on supine, and ± Valsalva maneuver			
Lungs				
Abdomen		_		
Skin				
Herpes simplex virus (HSV), lesions suggestive	e of methicillin-resistant <i>Staphylococ</i>	cus aureus (MRS/	A), or	
tinea corporis				
Neurological				AND THE CONTRACTOR OF THE CONT
MUSCULOSKELETAL			NORMAL	ABNORMAL FINDINGS
Neck				
Back				
Shoulder and arm				
Elbow and forearm				
Wrist, hand, and fingers				
Hip and thigh				
Knee				
Leg and ankle				
Foot and toes				
FunctionalDouble-leg squat test, single-leg squat test,	and box drop or step drop test			
^a Consider electrocardiography (ECG), echocardination of those.		or abnormal car	diac history or examina	ation findings, or a combi-
Name of health care professional (print or type):			Date:	
Signature of health care professional:				, MD, DO, NP, or P

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■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name:	Date of hirth		
☐ Medically eligible for all sports without restriction	Date of Birtin.		•
☐ Medically eligible for all sports without restriction with recommendations f	or further evaluation or treatmen	nt of	
☐ Medically eligible for certain sports			
☐ Not medically eligible pending further evaluation			
□ Not medically eligible for any sports			
Recommendations:			
I have examined the student named on this form and completed the paperent clinical contraindications to practice and can participate in the examination findings are on record in my office and can be made availarise after the athlete has been cleared for participation, the physician and the potential consequences are completely explained to the athlete	he sport(s) as outlined on this lable to the school at the req n may rescind the medical eli	s form. A copy of the p uest of the parents. If gibility until the proble	hysical 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:			25
			•
			- n
Medications:			•)
			- P
			20
Other information:			25 30
			78
			5 0
Emergency contacts:			ti.
			- 6

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■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	1
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		0
8. Do you have any rashes, pressure sores, or other skin problems?		1
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		Ĺ
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		
xplain "Yes" answers here.		
lease indicate whether you have ever had any of the following conditions:	Yes	1
	Yes	1
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability	Yes	ı
Atlantoaxial instability	Yes	I
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability	Yes	ı
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one)	Yes	N
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding	Yes	ı
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis	Yes	N
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel	Yes	1
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel	Yes	
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands	Yes	
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet	Yes	N
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands	Yes	
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet	Yes	
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet Recent change in coordination	Yes	
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk	Yes	
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida	Yes	
Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida Latex allergy	Yes	
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Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida Latex allergy	Yes	
Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida	Yes	
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Atlantoaxial instability Radiographic (x-ray) evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida Latex allergy xplain "Yes" answers here.		