Preparticipation Physical Evaluation

Student's Name:_____ Gender: _____ Age:_____ DOB:_____

Address: Phone:

School: Grade: Sport:

Personal Physician:_____ Phone:_____

In case of emergency, contact: (other than parent) Name:_____ *Relationship:*_____ *Phone(H)*_____*(W)*_____

	YES	NO		YES	NO
1)Has a doctor ever denied or restricted your participation in sports for any reason (including heart problems)?	☐	☐	31)Have you ever had a broken or fractured bone or dislocated joint?	☐	☐
2)Do you have any ongoing medical conditions or are you under a doctors care for any specific reason?	☐	☐	32)Have you ever had a stress fracture?	☐	☐
3)Are you currently taking any prescription or non-prescription medicines or using an inhaler?	☐	☐	33)Have you ever had an injury that required an x-ray, CT, MRI, injections, therapy, or a brace, cast, or crutches?	☐	☐
4)Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐	34)Do you use any protective or corrective equipment or devices that aren't usually used for your sport or position, including braces, orthotics, retainer on your teeth, hearing aids or other assistive device?	☐	☐
5)Have you been hospitalized overnight in the past year?	☐	☐	35)Do you have a bone, muscle, or joint injury that bothers you?	☐	☐
6)Have you ever spent the night in the hospital?	☐	☐	36)Do any of your joints become painful, swollen, feel warm, or look red?	☐	☐
7)Have you ever had surgery?	☐	☐	37)Do you get frequent muscle cramps when exercising?	☐	☐
8)Has a doctor ever ordered a test of your heart like an EKG or echo?	☐	☐	38)Have you ever become ill from exercising in the heat?	☐	☐
9)Have you ever gotten dizzy, light-headed, passed out or nearly passed out DURING or AFTER exercise?	☐	☐	39)Have you ever had or been told you should have an x-ray for neck instability or atlantoaxial instability (such as in Down Syndrome or Dwarfism)?	☐	☐
10)Do you ever get discomfort, pain, tightness or pressure in your chest during exercise?	☐	☐	40)Do you have any history of juvenile arthritis or connective tissue disease?	☐	☐
11)Does your heart ever race or skip beats during exercise?	☐	☐	41)Do you have any allergies (Ex., to pollen, medicine, food, or insects)?	☐	☐
12)Do you get more tired more quickly than your friends do during exercise?	☐	☐	42)Do you cough, wheeze, or have difficulty breathing during or after exercise? 40)Do you have asthma?	☐ ☐	☐ ☐
13)Do you get short of breath with exercise?	☐	☐	43)Have you ever taken an inhaler or asthma medicine? 43a)Is there anyone in your family who has asthma?	☐ ☐	☐ ☐
14)Have you ever had an unexplained seizure?	☐	☐	44)Do you have groin pain or a painful bulge or hernia in your groin area?	☐	☐
15)Have you ever been told you have any heart problems like a heart murmur, high blood pressure, high cholesterol, heart infection, Kawasaki disease, other? (circle those that apply)	☐	☐	45)Do you have any rashes, sores or other skin problems? 46)Have you had herpes or MRSA skin infections? 47)Do you or someone in your family have sickle cell trait or disease?	☐ ☐ ☐	☐ ☐ ☐
16)Have you had a severe viral infection like myocarditis or mono in the last month?	☐	☐	48)Have you had any problems with your eyes or vision? 49)Have you had any eye injuries?	☐ ☐	☐ ☐
17)Has any family member been diagnosed with an enlarged heart, dilated or hypertrophic cardiomyopathy, long QT syndrome, or abnormal heart rhythm, arrhythmogenic right ventricular cardiomyopathy, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐	50)Do you wear glasses or contact lenses? 50a)Do you wear protective eye gear, such as goggles or a face shield? 51)Do you worry about your weight?	☐ ☐ ☐	☐ ☐ ☐
18)Does anyone in the family have a heart problem, pacemaker, or implanted defibillator?	☐	☐	52)Are you trying or has someone recommended to you that you gain or lose weight?	☐	☐
19)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)?	☐	☐	53)Are you on a special diet or do you avoid certain types of food? 54)Have you ever had an eating disorder? 55)Do you feel stressed out?	☐ ☐ ☐	☐ ☐ ☐
20)Has any family member or relative had unexplained fainting, unexplained seizures, or near drowning?	☐	☐	*Females Only:* *56)Have you had a menstrual Period?*	☐	☐
21)Have you ever had a concussion or a head injury that caused confusion, prolonged headache, or memory problems? If so, how many?_____ How severe was each one? _____ When was your last concussion?	☐	☐	56a)How old were you when you first had your first menstrual period?_____ 56b)When was your most recent period? _____		
22)Have you ever been knocked out, became unconscious, or lost your memory? If so, how many times? _____	☐	☐	56b)How many periods have you had in the last 12 months? _____		
23)Do you have frequent or severe headaches or headaches with exercise?	☐	☐	56c)How much time do you usually have from the start of one period to the start of another? _____		
24)Have you had numbness or tingling in your arms, hands, legs, or feet?	☐	☐	56d)What was the longest time between periods in the past year? _____ *Males Only:*		
25)Have you ever had a seizure?	☐	☐	57)Do you have 2 testicles? 58)Do you have any testicular swelling or masses?	☐ ☐	☐ ☐
26)Were you born without or are you missing a kidney, eye, testicle, or your spleen or any other organ?	☐	☐	An individual answering in the affirmative to any questions relating to a possible cardiovascular health issue as identified on the form should be restricted from further participation until the individiual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.		
27)Have you ever had a stinger, burner, or a pinched nerve? 28) Have you ever been unable to move your arms or legs after getting hit or falling? 29)Have you ever had an injury to a bone, muscle ligament, or tendon that caused you to miss a practice or game?	☐ ☐ ☐	☐ ☐ ☐	Explain yes answers in the box below(attached another sheet if neccessary):_____		
30)Have you ever had an injury to a bone, muscle ligament, or tendon that caused you to miss a practice or game?	☐	☐			

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastics League nor the school assumes any responsibility in case an accident occurs. If, in the the judgement of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do herby request, authorize, and consent to such care and treatment as may given said student by any physician, athletic trainer, nurse or school representative. I do hearby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful Reponses could subject the student in question to penalties determined by the UIL.

Student Signature:_____ Parent Signature: _____ Date:_____

This Medical History Form was reviewed by: Name_____ Date_____ Signature:_____

Patient's 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?
- performance?
- Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms.

EXAMINATION

Height_____ Weight_____ Male Female

BP_____/_____ (/) Pulse _____ Vision R 20/ _____ L 20/ _____ Corrected Y _____ N _____

MEDICAL	NORMAL:	ABNORMAL FINDINGS:
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 a Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) b		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		
Duck-walk, single leg hop		

a. Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. b. Consider GU exam if in private setting. Having third party present is recommended.
c.Consider cognitive 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 participation in the sport(s) 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 of exam: _____

Address _____ Phone _____

Signature of physician _____ ,MD or NP