# ■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

# **HISTORY FORM**

Note: Complete and sign this form (with your p	, •	) before your appointment. Date of birth:
Date of examination:		
		your gender? (F, M, non-binary, or another gender):
Have you had COVID-19? (check one): □ Y	′ □N	
Have you been immunized for COVID-19? (c	heck one): □Y □N	If yes, have you had: □ One shot □ Two shots □ Three shots □ Booster date(s)
List past and current medical conditions.		
Have you ever had surgery? If yes, list all past	surgical procedures.	
Medicines and supplements: List all current pr	rescriptions, over-the-coun	ter medicines, and supplements (herbal and nutritional).
Do you have any allergies? If yes, please list of	all your allergies (ie, medi	cines, pollens, food, stinging insects).

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

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)			No	
1.	Do you have any concerns that you would like to discuss with your provider?			
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?			
HEA	HEART HEALTH QUESTIONS ABOUT YOU			
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?			
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.			

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)				
9. Do you get light-headed or feel shorter of breath than your friends during exercise?				
10.	Have you ever had a seizure?			
HEAI	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	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)?			
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

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?  16. Do you have a bone, muscle, ligament, or joint injury that bothers you?  16. Do you cough, wheeze, or have difficulty breathing during or ofter exercise?  17. Are you missing a kidney, an eye, a testicle, 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 Staphylococcus aureus (MRSA)?  20. Have you ever 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 had or do you have any problems with your eyes or vision?  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 problems with your eyes or vision?	26. Are you trying to or has anyone recommended that you gain or lose weight?  27. Are you or a special diet or do you avoid certain types of foods or food groups?  28. Hove you ever had an eating disorder?  29. Have you ever had a menstrual period?  30. How have groin or testicle pain or a painful bulge or hernia in the groin area?  20. You have any recurring skin rashes or ashes that come and go, including herpes or methicilin-resistant Staphylococcus aureus (MRSA)?  14 ave you had a concussion or head injury that acused confusion, a prolonged headache, or memory problems?  15 ave you ever had numbness, had fingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?  15 ave you ever had or do you have any problems with your eyes or vision?  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. Hove you ever had a menting disorder?  MENSTRUAL QUESTIONS  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?  Explain "Yes" answers here.  Explain "Yes" answers here.	108	IE AND JOINT QUESTIONS	Yes	No	MEI	DICAL QUESTIONS (CONTINUED)	Yes
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injury that bothers you?  EDICAL QUESTIONS 6. Do you cough, wheeze, or have difficulty breathing during or ofter exercise? 7. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ? 8. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? 9. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? 10. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? 11. 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? 12. Have you ever become ill while exercising in the heat? 13. Do you or does someone in your family have sickle cell trait or disease? 14. Have you ever had or do you have any problems with your eyes or vision?  15. When was you when you had your first menstrual period? 16. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? 17. Are you when you had a menstrual period? 18. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? 19. How wou wen had a menstrual period? 19. How many periods have you had in the past 12 months?  Explain "Yes" answers here.  10. Have you ever had on do you have any problems with your eyes or vision?  10. Have you ever had an eating disorder?  10. How old were you when you had your first menstrual period? 10. How many periods have you had in the past 12 months?  11. 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?  11. Have you ever had numbness, had tingling had weakness in your arms or legs, or been unable to move your arms or legs or been unable to move your arms or legs or been unable to move your arms or legs or been unable to move your arms or legs of the been your arms or legs or been unable	injury that bothers you?  CAL QUESTIONS  Or you cough, wheeze, or have difficulty breathing during or after exercise?  Are you missing a kidney, an eye, a testicle, your pleen, or any other organ?  Or you have any recurring skin rashes or cashes that come and go, including herpes or inethicillin-resistant Staphylococcus aureus (MRSA)?  It are you what a concussion or head injury that caused confusion, a prolonged headache, or memory problems?  It are you ever had an eating disorder?  MENSTRUAL QUESTIONS  N/A  Yes  MENSTRUAL QUESTIONS  N/A  Yes  No  Menstrual Questions  N/A  Yes  Menstrual Questions  N/A  Yes  Menstrual Questions  N/A  Yes  No  No  N/A  Yes  No  No  Menstrual Questions  N/A  Yes  No  No  Menstrual Questions  N/A  Yes  No  No  No  Menstrual Questions  N/A  Yes  No  No  No  No  No  No  No  No  No  N					26.		
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# ■ PREPARTICIPATION PHYSICAL EVALUATION

# ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: Date of birth:		
1. Type of disability:		
2. Date of disability:		
3. Classification (if available):	1	
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
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?		
8. Do you have any rashes, pressure sores, or other skin problems?		
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?		
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?		
Explain "Yes" answers here.		
Please indicate whether you have ever had any of the following conditions:	1	
	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Dislocated joints (more than one) Easy bleeding		
Dislocated joints (more than one)  Easy bleeding  Enlarged spleen		
Dislocated joints (more than one)  Easy bleeding  Enlarged spleen  Hepatitis		
Dislocated joints (more than one)  Easy bleeding  Enlarged spleen  Hepatitis  Osteopenia or osteoporosis		
Dislocated joints (more than one)  Easy bleeding  Enlarged spleen  Hepatitis  Osteopenia or osteoporosis  Difficulty controlling bowel		
Dislocated joints (more than one)  Easy bleeding  Enlarged spleen  Hepatitis  Osteopenia or osteoporosis  Difficulty controlling bowel  Difficulty controlling bladder		
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		
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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		
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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		
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		
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  Explain "Yes" answers here.	and corre	ct.
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	and corre	ct.
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  Explain "Yes" answers here.	and corre	ct.

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### ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name:	Date of birth:

#### **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, e-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-enhancing supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- 2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

EXAMINATION				
Height: Weight:				
BP: / ( / ) Pulse: Vision: R 20/	L 20/	Correc	ted: 🗆 Y [	 □ N
MEDICAL			NORMAL	ABNORMAL FINDINGS
Appearance  • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachno myopia, mitral valve prolapse [MVP], and aortic insufficiency)	odactyly, hyperla	xity,		
Eyes, ears, nose, and throat  Pupils equal  Hearing				
Lymph nodes				
Heart <sup>a</sup> Student has had COVID infection in past several months and needs cardit • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	is-related restric	ctions		
Lungs				
Abdomen				
Skin  Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococ tinea corporis	cus aureus (MRS	6A), or		
Neurological				
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				
Functional     Double-leg squat test, single-leg squat test, and box drop or step drop test				
<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist fo nation of those.	r abnormal card	liac histo	ry or examin	ation findings, or a combi-
Name of health care professional (print or type):			Dat	e:
Address:				
Signature of health care professional:				, MD, DO, NP, or PA

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<sup>\*</sup>Health professionals: please also sign the following page (page 5)

### ■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM					
Name: Do	ate of birth:				
☐ Medically eligible for all sports without restriction					
□ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment 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 prepartic apparent clinical contraindications to practice and can participate in the spot examination findings are on record in my office and can be made available arise after the athlete has been cleared for participation, the physician may rand the potential consequences are completely explained to the athlete (and	rt(s) as outlined on this form. A copy to the school at the request of the pa escind the medical eligibility until the	of the physical rents. If 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:		<u> </u>			
Medications:					
Other information:		<u> </u>			
Emergency contacts:					

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