# Forks Community Hospital

"Pioneers in Rural Health Care"

## Pre-Participation Physical Evaluation
## (Sports Physical)

Attached is a questionnaire to be filled out by the parent/guardian and/or the athlete prior to the athlete seeing the provider. The provider will review the questionnaire at the athlete's sports physical appointment. At these appointments no other health concerns are addressed unless it affects the athlete's ability to participate in sports. Should there be health concerns found during the physical exam, the sports physical may be cancelled, and an office visit will be billed to your insurance. This is to assure the health concerns/findings are addressed in the best interest of the athlete. Pre-participation physical evaluations should occur approximately six weeks before activity to allow for further evaluation, treatment, or rehabilitation as needed.

### What is the Pre-participation Physical Evaluation (PPE)?

The overarching goal in performing a pre-participation physical evaluation (PPE) is to promote the health and safety of the athlete in training and competition. The PPE provides the medical background on which physical activity decisions will be made by the individual athlete's practitioner or the team practitioner and associated medical staff.

### Who developed the guidance?

The American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports developed the PPE Monograph that provides a detailed description of goals, objectives, timing, setting, and structure of the exam; details the history, physical examination, and clearance considerations; lists return-to-play guidelines; addresses medicolegal and ethical concerns; and explores future research and the use of electronic formats.


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| GENERAL QUESTIONS | Yes | No |
|---|---|---|
| 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:<br>☐ Asthma ☐ Anemia ☐ Diabetes<br>☐ Infections<br>Other: | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 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 or heart related problems? If so, check all that apply:<br>☐ High blood pressure ☐ Heart murmur<br>☐ High cholesterol ☐ Heart infection<br>☐ Kawasaki disease<br>☐ Other: | | |
| 9. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 10. Have you ever had an unexplained seizure? | | |
| 11. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 12. 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)? | | |
| 13. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 14. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 15. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 16. Have you ever had an injury to a bone, muscle, ligament, or tendon injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 17. Have you ever been told that you have, or have you had an x-ray for neck instability or atlantoaxial instability? (as seen in Down syndrome or dwarfism) | | |
| 18. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 19. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 20. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 21. Do you have any history of juvenile arthritis or connective tissue disease? | | |
| 22. Must you use any special equipment for competition (pads, braces, neck roll, etc.)? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 23. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 24. Have you ever used an inhaler or taken asthma medicine? | | |
| 25. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 26. Have you had infectious mononucleosis (mono) within the last month? | | |
| 27. Have you ever had a head injury or concussion? | | |
| 28. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 29. Do you have a history of seizure disorder? | | |
| 30. Do you have headaches with exercise? | | |
| 31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 32. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 33. Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? | | |
| 34. Do you get frequent muscle cramps when exercising? | | |
| 35. Have you had any problems with your eyes or vision? | | |
| 36. Have you had any eye injuries | | |
| 37. Do you wear glasses or contact lenses? | | |
| 38. Do you worry about your weight? | | |
| 39. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 40. Are you on a special diet or do you avoid certain types of foods? | | |
| 41. Have you ever had an eating disorder? | | |
| 42. Do you have any concerns that you would like to discuss with a doctor or medical concerns about participating in your sport? | | |
| **FEMALES ONLY** | **Yes** | **No** |
| 43. Have you ever had a menstrual period? | | |
| 44. How old were you when you had your first menstrual period? | | |

**Explain "yes" answers here**

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

**Signature of athlete** _____

**Date & Time** _____

**Signature of parent/guardian** _____

**Date & Time** _____

# Pre-Participation Physical Evaluation Form

Name _____ Date of Birth _____ Date of Exam _____
Age _____ Grade _____ School/School Year_____ Sport(s) _____ Date of Last Physical _____

**PROVIDER REMINDER'S**

- 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?
- Do you use tobacco products, snuff, or dip?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or used any other performance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?

Medicines: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking: (including birth control, aspirin, Tylenol, ibuprofen, etc.)

_____

_____

Do you have any allergies? Yes No ☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects ☐ Other

Reactions/Adverse Events: (rash, or breathing difficulties) _____

**PROVIDER EXAMINATION (FOR OFFICAL USE ONLY)**

Height_____ Weight _____ ☐ Male ☐ Female

BP / Pulse Vision R 20/ L 20/ Corrected Y N

| MEDICAL | NORMAL | ABNORMAL FINDINGS |
|---|---|---|
| Appearance | | |
| Eyes/ears/nose/throat | | |
| Lymph nodes | | |
| Heart<br>• Murmurs | | |
| Pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only) | | |
| Skin<br>• HSV, lesions suggestive of MRSA or tinea corporis | | |
| Neurologic | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back/Spine | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh/knee | | |
| Ankle/foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

☐ Cleared for all sports without restriction
☐ Not cleared
  ☐ Reason_____
  ☐ Recommendations_____
☐ Cleared with restrictions below:
  ☐ Pending further evaluation
  ☐ Reason_____
  ☐ Restrictions/Recommendations_____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. 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 provider (print/type) Signature of provider Date & Time

_____
Clinic Name/Phone Number