Preparticipation Physical Exam
History Form

Date of Exam _____

Name _____ Date of Birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections 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? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____	☐	☐
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	☐	☐
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐
11. Have you ever had an unexplained seizure?	☐	☐
12. Do you get more tired or short of breath more quickly than your friends during exercise?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. 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)?	☐	☐
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhymogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator	☐	☐
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	☐	☐
18. Have you ever had any broken or fractured bones or dislocated joints?	☐	☐
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	☐	☐
20. Have you ever had a stress fracture?	☐	☐
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	☐	☐
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial 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?	☐	☐

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
27. Have you ever used an inhaler or taken asthma medicine?	☐	☐
28. Is there anyone in your family who has asthma?	☐	☐
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
30. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
31. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
32. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
33. Have you had herpes or MRSA skin infection?	☐	☐
34. Have you ever had a head injury or concussion?	☐	☐
35. Have you ever had a hit or blow to the head that cause confusion, prolonged headache, or memory problems?	☐	☐
36. Do you have a history of seizure disorder?	☐	☐
37. Do you have headaches with exercise?	☐	☐
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
39. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
40. Have you ever become ill while exercising in the heat?	☐	☐
41. Do you get frequent muscle cramps when exercising?	☐	☐
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?	☐	☐
44. Have you had any eye injuries?	☐	☐
45. Do you wear glasses or contact lenses?	☐	☐
46. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
47. Do you worry about your weight?	☐	☐
48. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
49. Are you on a special diet or do you avoid certain types of foods?	☐	☐
50. Have you ever had an eating disorder?	☐	☐
51. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?	☐	☐
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

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 _____ Signature of parent/guardian _____ Date _____

* Modified from "Preparticipation Physical Evaluation Form" ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Preparticipation Physical Exam
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, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, sniff, 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?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height	Weight	☐ Male ☐ Female
BP / (/)	Pulse	Vision R 20/ L 20/ Corrected ☐ Y ☐ N

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscolisis, 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 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 for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named athlete and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contradictions to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available at the request of the parents. If conditions arise after the athlete has been cleared for participation, the clinician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of clinician (print/type) _____ Date _____

Address Imperial County Public Health Department 935 Broadway St, El Centro CA 92243 Phone +1 (442) 265-1420

Signature of clinician _____ , MD or PA

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Preparticipation Physical Exam
Clearance Form

Name _____ Sex ☐ M ☐ F Age _____ Date of Birth _____

☐ 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 athlete and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available 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 clinician (print/type): _____ Date: _____

Address: Imperial County Public Health Department 935 Broadway St, El Centro CA 92243 Phone: +1 (442) 265-1420

Signature of clinician: _____ , MD or PA

EMERGENCY INFORMATION

Allergies _____

Other information _____

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