



# Preparticipation Physical Evaluation

## HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart. Physical must be completed within 6 months prior to any ESU athletic participation)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Year \_\_\_\_\_ Sport(s) \_\_\_\_\_ ESU Student ID \_\_\_\_\_

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

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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	MEDICAL QUESTIONS		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?				26. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____				27. Have you ever used an inhaler or taken asthma medicine?			
3. Have you ever spent the night in the hospital?				28. Is there anyone in your family who has asthma?			
4. Have you ever had surgery?				29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?			
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?				31. Have you had infectious mononucleosis (mono) within the last month?			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				32. Do you have any rashes, pressure sores, or other skin problems?			
7. Does your heart ever race or skip beats (irregular beats) during exercise?				33. Have you had a herpes or MRSA skin infection?			
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____				34. Have you ever had a head injury or concussion?			
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)				35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
10. Do you get lightheaded or feel more short of breath than expected during exercise?				36. Do you have a history of seizure disorder?			
11. Have you ever had an unexplained seizure?				37. Do you have headaches with exercise?			
12. Do you get more tired or short of breath more quickly than your friends during exercise?				38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?			
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)?				40. Have you ever become ill while exercising in the heat?			
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?				41. Do you get frequent muscle cramps when exercising?			
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				42. Do you or someone in your family have sickle cell trait or disease?			
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?				43. Have you had any problems with your eyes or vision?			
BONE AND JOINT QUESTIONS		Yes	No	44. Have you had any eye injuries?			
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?				45. Do you wear glasses or contact lenses?			
18. Have you ever had any broken or fractured bones or dislocated joints?				46. Do you wear protective eyewear, such as goggles or a face shield?			
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				47. Do you worry about your weight?			
20. Have you ever had a stress fracture?				48. Are you trying to or has anyone recommended that you gain or lose weight?			
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)				49. Are you on a special diet or do you avoid certain types of foods?			
22. Do you regularly use a brace, orthotics, or other assistive device?				50. Have you ever had an eating disorder?			
23. Do you have a bone, muscle, or joint injury that bothers you?				51. Do you have any concerns that you would like to discuss with a doctor?			
24. Do any of your joints become painful, swollen, feel warm, or look red?				<b>FEMALES ONLY</b>			
25. Do you have any history of juvenile arthritis or connective tissue disease?				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

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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 \_\_\_\_\_

Name \_\_\_\_\_

ESU Student ID# \_\_\_\_\_

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, 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?
  - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		Weight	Height	Male	Female	Sickle Cell Trait Status	Positive	Negative	Waiver
BP	/	( / )	Pulse	Vision R 20/		L 20/	Corrected	<input type="checkbox"/> Y	<input type="checkbox"/> N
MEDICAL				NORMAL		ABNORMAL FINDINGS			
Appearance									
<ul style="list-style-type: none"> <li>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>									
Eyes/ears/nose/throat									
<ul style="list-style-type: none"> <li>• Pupils equal</li> <li>• Hearing</li> </ul>									
Lymph nodes									
Heart <sup>a</sup>									
<ul style="list-style-type: none"> <li>• Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>• Location of point of maximal impulse (PMI)</li> </ul>									
Pulses									
<ul style="list-style-type: none"> <li>• Simultaneous femoral and radial pulses</li> </ul>									
Lungs									
Abdomen									
Genitourinary (males only) <sup>b</sup>									
Skin									
<ul style="list-style-type: none"> <li>• HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>									
Neurologic <sup>c</sup>									
MUSCULOSKELETAL									
Neck									
Back									
Shoulder/arm									
Elbow/forearm									
Wrist/hand/fingers									
Hip/thigh									
Knee									
Leg/ankle									
Foot/toes									
Functional									
<ul style="list-style-type: none"> <li>• Duck-walk, single leg hop</li> </ul>									

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiologist for abnormal cardiac history or exam.<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.**Date of last Tetanus: Td or Tdap (required within last 10 years):** \_\_\_\_\_

**CLEARED for all sports without restriction**       **CLEARED for all sports with limitations**  
 **NOT CLEARED**       **Pending further evaluation**

**Reason:**

I have examined the above-named student 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. 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 \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

**Stamp not accepted****Physician's License#** \_\_\_\_\_