■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

	Date of birth:		
ate of examination:	Sport(s):		
ex assigned at birth (F, M, or intersex):	How do you identify your gender? (F, M, or other):		
List past and current medical conditions.			
Have you ever had surgery? If yes, list all past surgi	cal procedures.		
Medicines and supplements: List all current prescrip	ptions, over-the-counter medicines, and supplements (herbal and nutritional).		
Da van hang any allowies? If you place list all yo	our allergies (ie, medicines, 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	1	2	3		
Not being able to stop or control worrying	0	1	2	3		
Little interest or pleasure in doing things	0	1	2	3		
Feeling down, depressed, or hopeless	0	1	2	3		
(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)						

(Ехр	ERAL QUESTIONS lain "Yes" answers at the end of this form. e questions if you don't know the answer.)	Yes	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	RT HEALTH QUESTIONS ABOUT YOU	Yes	No
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.		

	RT HEALTH QUESTIONS ABOUT YOU NTINUED)	Yes	No
9.	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10.	Have you ever had a seizure?		
HEA	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	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			25. Do you worry about your weight?		
	caused you to miss a practice or game?			26. Are you trying to or has anyone recommended that you gain or lose weight?		
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?		
MEI	DICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMALES ONLY	Yes	No
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			29. Have you ever had a menstrual period? 30. How old were you when you had your first menstrual period?		<u> </u>
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			31. When was your most recent menstrual period?		
19.	Do you have any recurring skin rashes or			32. How many periods have you had in the past 12 months?		
	rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			Explain "Yes" answers here.		
20.	Have you 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 become ill while exercising in the heat?					
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 prob- lems with your eyes or vision?					

Yes No

BONE AND JOINT QUESTIONS

Date: _

MEDICAL QUESTIONS (CONTINUED)

Yes No

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■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: Date of birth:			
1. Type of disability:			
Date of disability:			
Classification (if availed a superior of the superior of			
	rth, disease, injury, or other):		
5. List the sports you are	, ,		
3. 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?	les	INO
	al brace or assistive device for sports?	+-	\vdash
	nes, pressure sores, or other skin problems?	+-	
	g loss? Do you use a hearing aid?	+-	\vdash
10. Do you have a visual		+-	\vdash
	al devices for bowel or bladder function?	+-	\vdash
	or discomfort when urinating?	+-	\vdash
	<u> </u>	+	-
13. Have you had autono	,	+-	
-	agnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?	+-	
15. Do you have muscle s	·	+-	\vdash
<u> </u>	seizures that cannot be controlled by medication?		
Explain "Yes" answers	here.		
Diama indiama whatha	r you have ever had any of the following conditions:		
Please indicate whether	you have ever had any or the following conditions:		
Ad a transfer		Yes	No
Atlantoaxial instability	Lieuf all a le le a leis	+-	\vdash
	uluation for atlantoaxial instability	+	
Dislocated joints (more than	i one)	+	
Easy bleeding		+	\vdash
Enlarged spleen		+	
Hepatitis		+-	
Osteopenia or osteoporosis	i	+	
Difficulty controlling bowel		+	
Difficulty controlling bladde		+	
Numbness or tingling in an		+	
Numbness or tingling in leg		+	igsquare
Weakness in arms or hand	\$	+	igsquare
Weakness in legs or feet		\bot	
Recent change in coordinat		\bot	
Recent change in ability to	walk	\bot	
Spina bifida		\perp	
Latex allergy			
Explain "Yes" answers	here.		
•	he best of my knowledge, my answers to the questions on this form are complete a	nd corre	ect.
Signature of athlete:			
Date:			

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