



# HISTORY FORM | Preparticipation Physical Evaluation

(Note: This form is to be filled out by the patient and parent prior to seeing the medical provider. The medical provider should keep this form in the student's medical file. This form does not get returned to the athletic department.)

Date of Exam				Date of Birth		OSIS#	
Last Name			First Name			Sport(s)	
Sex	Age	Grade	School	School Campus			

## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please identify specific allergy below: <input type="checkbox"/> Medicines _____ <input type="checkbox"/> Pollens <input type="checkbox"/> Food _____ <input type="checkbox"/> Stinging Insects <input type="checkbox"/> Latex		Do you carry an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you carry an Epi Pen? <input type="checkbox"/> Yes <input type="checkbox"/> No

## 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?			25.	Do you have any history of juvenile arthritis or connective tissue disease?		
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 <input type="checkbox"/> sickle cell disease or trait Other: _____			26.	Do any of your joints become painful, swollen, warm, or look red?		
3.	Have you ever been admitted to the hospital?			27.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
4.	Have you ever had surgery?			28.	Have you ever used an inhaler or taken asthma medicine?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>				29.	Is there anyone in your family who has asthma?		
5.	Have you ever passed out or nearly passed out DURING or AFTER exercise?	Yes	No	30.	Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
6.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			31.	Do you have groin pain or a painful bulge or hernia in the groin area?		
7.	Does your heart ever race or skip beats while resting or during exercise?			32.	Have you had infectious mononucleosis (mono) within the last month?		
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: _____			33.	Do you have any rashes, pressure sores, or other skin problems?		
9.	Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			34.	Have you had a herpes or MRSA skin infection?		
10.	Do you get lightheaded or feel more short of breath than expected during exercise?			35.	Have you ever had a head injury or concussion?		
11.	Do you get more tired or short of breath more quickly than your friends during exercise?			36.	Have you ever had an unexplained seizure?		
12.	Have you ever had any heart surgery?			37.	Have you ever had a hit or blow to the head that caused confusion, long-lasting headache, or memory problems?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>				38.	Do you have a history of seizure disorder?		
13.	Does anyone in your family have an irregular heartbeat?	Yes	No	39.	Do you have headaches with exercise?		
14.	Has any family member of 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 had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
15.	Does anyone in your family have a heart problem, pacemaker, or defibrillator?			41.	Have you ever been unable to move your arms or legs after being hit or falling?		
16.	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			42.	Have you ever become ill while exercising in the heat?		
17.	Do you or someone in your family have sickle cell trait or disease?			43.	Do you get frequent muscle cramps when exercising?		
<b>BONE AND JOINT QUESTIONS</b>				44.	Have you had any problems with your eyes or vision?		
18.	Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	Yes	No	45.	Have you had any eye injuries?		
19.	Have you ever had any broken or fractured bones or dislocated joints?			46.	Do you wear glasses or contact lenses?		
20.	Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47.	Do you wear protective eyewear, such as goggles or a face shield?		
21.	Have you ever had a stress fracture?			48.	Have you ever had hearing loss or problems with your hearing?		
22.	Have you ever been told that you have or have you had an x-ray for neck instability? (Down syndrome or dwarfism)			49.	Do you worry about your weight?		
23.	Do you regularly use a brace, orthotics, or other device?			50.	Are you trying to or has anyone recommended that you gain or lose weight?		
24.	Do you have a bone, muscle, or joint injury that bothers you?			51.	Are you on a special diet or do you avoid certain types of foods?		
				52.	Have you ever had an eating disorder?		
				53.	Do you have any concerns that you would like to discuss with a doctor?		
				54.	Do you have any other medical problems?		
				<b>FEMALES ONLY</b>		Yes	No
				55.	Have you ever had a menstrual period?		
				56.	Have you had any problems with your periods (severe cramps, heavy bleeding)?		
				57.	When was your last period? _____		
				58.	What is the frequency of your periods? _____		
				<b>Explain "yes" answers here</b>			

I have reviewed the History Form and I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct. I give permission for \_\_\_\_\_ (Child's Name) to have a physical examination, which will include an inguinal and testicular examination for boys and an inguinal examination for girls. If this exam is performed in the school setting, I understand that if either I or my child refuses to have these areas examined, the OSH Medical provider will not be able to complete this form and clear my child for participation.

Parent/Guardian Name	
Parent/Guardian Signature	Date
Phone #	



# PHYSICAL EXAMINATION FORM | Preparticipation Physical Evaluation

NOTE: The medical provider should keep this form in the student's medical file. This form does not get returned to the athletic department.

Last Name	First Name	Date of Birth
School/Campus/ATSDBN	Grade	OSIS#

STUDENT'S HISTORY FORM REVIEWED BY MEDICAL PROVIDER	YES NO
PHYSICIAN REMINDER - Consider the questions below	COMMENTS
Do you feel safe at your home or residence?	
Do you feel safe at school?	
Do you ever feel stressed out or under a lot of pressure?	
Do you ever feel sad, hopeless, depressed, or anxious?	
Have there been any changes in your weight?	
Have you ever taken any supplements to help you gain or lose weight or improve your performance?	
Have you ever taken anabolic steroids or used any other performance supplement?	
Have you ever tried cigarettes, alcohol, or other drugs?	
During the past 30 days, did you use cigarettes, alcohol or other drugs?	
Are you sexually active?	
Are you using contraceptives?	
Do you wear a seat belt?	

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP	Pulse	Vision R20/	Corrected
/		L20/	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	NORMAL	ABNORMAL FINDINGS
<b>Appearance</b> • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP)		
<b>Eyes/ears/nose/throat</b> • Pupils equal • Hearing		
<b>Lymph nodes</b>		
<b>Heart<sup>a</sup></b> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
<b>Pulses</b> • Simultaneous femoral and radial pulses		
<b>Lungs</b>		
<b>Abdomen</b>		
<b>Genitourinary (males only)<sup>b</sup></b>		
<b>Skin</b> • HSV, lesions suggestive of MRSA, tinea corporis		
<b>Neurologic<sup>c</sup></b>		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
<b>Neck</b>		
<b>Back (including scoliosis screening)</b>		
<b>Shoulder/arm</b>		
<b>Elbow/forearm</b>		
<b>Wrist/hand/fingers</b>		
<b>Hip/thigh</b>		
<b>Knee</b>		
<b>Leg/ankle</b>		
<b>Foot/toes</b>		
<b>Functional</b> • Duck-walk, single leg hop		

<sup>a</sup> Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. <sup>b</sup> GU exam must be done in a private setting; the presence of a third party/chaperone is needed. It should not be performed in mass participation settings. <sup>c</sup> consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion. I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) outlined on the Recommendations for Participation in Physical Education and Sports form. This form may be rescinded until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Date	License/NPI Number
Address	Phone	
Signature of Medical Provider		
		STAMP HERE

