# Athletic Preparticipation Exam
## HISTORY FORM

**Note**: *Complete and sign this form (with your parents if younger than 18) before your appointment.*

**Name**: _____ **Date of birth**: _____

**Date of examination**: _____ **Sport(s)**: _____

**Sex assigned at birth (F, M, or intersex)**: _____ **How do you identify your gender? (F, M, or other)**: _____

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**List past and current medical conditions.** _____

**Have you ever had surgery? If yes, list of past surgical procedures.** _____

**Medicines and supplements: list all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).**

**Do you have allergies? If yes, please list all your allergies (i.e., 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 |

| GENERAL QUESTIONS<br>Explain Yes answers at the end of this form. Circle 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 a restricted your participation in sports for any reason? | | |
| 3. Do you have any ongoing medical issues or recent illnesses? | | |
| **HEART 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 skipped beats (irregular beats) during exercise? | | |
| 7. Has the doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | | |
| 8. Has the doctor ever told you that you have any heart problems? | | |
| 9. Do you get lightheaded or feel shorter of breath than your friends during exercise? | | |
| 10. Have you ever had a seizure? | | |
| **HEART 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, including drowning or an 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 as (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia CPVT? | | |

| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY (CONTINUED) | Yes | No |
|---|---|---|
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | | |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | | |
| **MEDICAL QUESTIONS** | **Yes** | **No** |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 18. Do you have groin or testicle pain (males) or a painful bulge or hernia in the groin area? | | |
| 19. Do you have any recurring skin rashes or rashes that, and go including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)? | | |
| 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 problems with your eyes or vision? | | |
| 25. Do you worry about your weight? | | |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | | |

| MEDICAL QUESTIONS (CONTINUED) | Yes | No |
|---|---|---|
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | | |
| 28. Have you ever had an eating disorder? | | |
| **FEMALES ONLY** | **Yes** | **No** |
| 29. have you ever had a menstrual period? | | |
| 30. How old were you when you had your first menstrual period? | | |
| 31. When was your most recent menstrual period? | | |
| 32. How many periods have you had in the past 12 months? | | |

## Explain "yes" answers here.

# Physical Examination

**Name**: _____ **Date of birth**: _____

**Class**: Fr. / So. / Jr. / Sr. / 5th **Sex:** M / F **Sport(s)**: _____

**To be completed by Physician(s) only:**

| | | | |
|---|---|---|---|
| **Height**: _____<br>**Weight**: _____ | **Vision**: Uncorrected / Corrected<br>**Left eye**: _____ / _____<br>**Right eye**: _____ / _____ | **Blood Pressure**:<br>_____ / _____ | **ADD/ADHD**: Yes / No<br>**If yes, please list medication:** |

| Skin | WNL | Abnormal Findings | Head | WNL | Abnormal Findings |
|---|---|---|---|---|---|
| Scars | | | Eyes | | |
| Birthmarks | | | Ears | | |
| Texture | | | Nose | | |
| Tattoos | | | Mouth | | |
| **Neck** | **WNL** | **Abnormal Findings** | **Abdomen** | **WNL** | **Abnormal Findings** |
| Thyroid | | | Contour | | |
| Trachea | | | Tenderness | | |
| Veins | | | Organs | | |
| Arteries | | | Masses | | |
| Spine | | | Hernia (Male) | | |
| Disc | | | Inguinal Nodes | | |
| **Back** | **WNL** | **Abnormal Findings** | **Back** | **WNL** | **Abnormal Findings** |
| Curvature | | | Trunk Ext | | |
| Spondylolisthesis | | | Lateral Flex | | |
| L5-S1 | | | Trunk Rotation | | |
| Hamstring Tightness | | | Patellar Reflex | | |
| Trunk Flex | | | Achilles Reflex | | |

| Orthopedic Evaluation of Extremities/Joints | | | **Additional Comments / Concerns:** |
|---|---|---|---|
| **Musculoskeletal** | **WNL** | **Abnormal Findings** | |
| Neck | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand/Fingers | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot/Toes | | | |
| Functional | | | |

**Physician Reminders**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you feel safe at your home or residence?
   - 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 4–13 on history form)

## Summary of Findings

## Medical Clearance

❑ Cleared for all sports

❑ Cleared for non-contact sports only

❑ Cleared after evaluation for: _____

❑ Not Cleared. Reason: _____

**Physician's Signature**: _____ **Date**: _____

**Address**: _____ **Phone Number**: (____)_____