

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.)

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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <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: _____		
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, arrhythmogenic 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?		
BONE AND JOINT QUESTIONS	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)		
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 a 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 caused 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		
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 _____

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HE0503 9-2681/0410



**SOUTH DAKOTA HIGH SCHOOL
ACTIVITIES ASSOCIATION
PHYSICAL EXAMINATION FORM**

Date Exam Expires: _____

Check Appropriate Physical Exam Term:
 Annual Biennial Triennial

NAME _____ GRADE _____ DATE OF BIRTH _____

CHECK ONE: MALE FEMALE (2017-18 School Year)

1. Blood pressure (sitting) _____/_____/_____ Repeat in 5 minutes, if elevated _____/_____/_____.

2. Height _____

3. Weight _____

	Normal	Abnormal	COMMENTS
4. Vision 20/_____ (L) 20/_____ (R)	_____	_____	_____

5. Head	_____	_____	_____
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6. Mouth (dentures, braces?)	_____	_____	_____
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7. Eyes (contacts?)	_____	_____	_____
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8. Chest/lung	_____	_____	_____
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9. Heart			
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a. Heart sounds	_____	_____	_____
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b. Murmurs	_____	_____	_____
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c. pulse (rad. vs fem.)	_____	_____	_____
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d. rhythm	_____	_____	_____
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10. Abdomen			
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a. liver or spleen	_____	_____	_____
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b. masses	_____	_____	_____
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11. Genitalia (males only)			
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a. hernias	_____	_____	_____
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b. testes	_____	_____	_____
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12. Orthopedic			
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a. cervical spine	_____	_____	_____
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b. shoulder shrug	_____	_____	_____
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c. deltoid	_____	_____	_____
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d. arms/elbow	_____	_____	_____
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e. hands	_____	_____	_____
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f. hips	_____	_____	_____
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g. knees	_____	_____	_____
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h. ankles	_____	_____	_____
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i. Scoliosis	_____	_____	_____
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SPORTS PARTICIPATION RECOMMENDED FOR:

_____ Cleared for ALL (*collision, contact/endurance sports, and other sports*)

_____ Cleared only for *contact/endurance sports and other sports*

_____ Cleared only for *other sports*

Definition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

_____ Cleared for ALL, but with recommendations for further evaluation or treatment for _____

_____ Above clearance to be granted only after _____

_____ **Clearance cannot be given at this time because** _____

NAME OF EXAMINER (PRINT) _____ DATE _____, 20____

SIGNATURE OF EXAMINER _____

NOTE: The following licensed medical personnel are qualified to perform the examination and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physician Assistant and licensed Nurse Practitioner.