This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

## PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance) 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, non-binary, or another gender):
Have you had COVID-19? (check one): 🗆 Y 🛛	N

 $\Box$  Three shots  $\Box$  Booster date(s)

Have you been immunized for COVID-19? (check one):  $\Box$  Y  $\Box$  N If yes, have you had:  $\Box$  One shot  $\Box$  Two shots

List past and current medical conditions.

Have you ever had surgery? If yes, list all past surgical procedures.

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

Do you have any allergies? If yes, please list all your 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  $\geq$ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

(Exp	IERAL QUESTIONS lain "Yes" answers at the end of this form. Circle stions 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.		

	ART HEALTH QUESTIONS ABOUT YOU		Yes	No
9.	Do you get light-headed or feel shorter of brea than your friends during exercise?	ath		
10.	Have you ever had a seizure?			
HEA	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	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 cardio- myopathy (HCM), Marfan syndrome, arrhyth- mogenic 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?			

BON	IE 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?		
MED	ICAL 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, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (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 Unsure have sickle cell trait or disease?		
24.	Have you ever had or do you have any problems with your eyes or vision?		

MED	DICAL QUESTIONS (CONTINUED)		Yes	No
25.	Do you worry about your weight?			
26. Are you trying to or has anyone recommended that you gain or lose weight?				
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?				
Men	ISTRUAL QUESTIONS	N/A	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.

### I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete:	
Signature of parent or guardian:	
Date:	_
	-

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Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

Date of birth: \_\_\_

## PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance) PHYSICAL EXAMINATION FORM

Name: \_

#### **PHYSICIAN REMINDERS**

Signature of health care professional:

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, e-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-enhancing 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 (Q4-Q13 of History Form).

EXAMINATION			
Height: Weight:			
BP: / ( / ) Pulse: Vision: R 20/ L 20/ Correc	ted: 🗆 Y 🛛	□N	
COVID-19 VACCINE			
Previously received COVID-19 vaccine: 🗆 Y 🗆 N			
Administered COVID-19 vaccine at this visit: □ Y □ N If yes: □ First dose □ Second dose □ Third do	ose 🗆 Boost	er date(s)	
MEDICAL	NORMAL	ABNORMAL FINDINGS	
<ul> <li>Appearance</li> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>			
Eyes, ears, nose, and throat • Pupils equal • Hearing			
Lymph nodes			
<ul> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>			
Lungs			
Abdomen			
<ul> <li>Skin</li> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis</li> </ul>			
Neurological			
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	
Neck			
Back			
Shoulder and arm			
Elbow and forearm			
Wrist, hand, and fingers			
Hip and thigh			
Knee			
Leg and ankle			
Foot and toes			
<ul> <li>Functional</li> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>			
<ul> <li><sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.</li> <li>Name of health care professional (print or type):</li></ul>			
	one:		

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, MD, DO, NP, or PA

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# PREPARTICIPATION PHYSICAL EVALUATION ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:

Date of birth: \_\_\_\_\_

I. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. 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?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
II. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

#### Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		
Explain "Yes" answers here.		

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct. Signature of athlete:

Signature of parent or guardian:	•
Date:	

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