

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, or other): _____

Have you had COVID-19? (check one): Y N

Have you been immunized for COVID-19? (check one): Y N If yes, have you had: One shot 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 ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (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 or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
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 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.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	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?		
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 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?		

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 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 have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL 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?		
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.

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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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION			
Height:	Weight:		
BP: / (/)	Pulse:	Vision: R 20/ L 20/	Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
COVID-19 VACCINE			
Previously received COVID-19 vaccine:	<input type="checkbox"/> Y <input type="checkbox"/> N		
Administered COVID-19 vaccine at this visit:	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes: <input type="checkbox"/> First dose <input type="checkbox"/> Second dose	
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 			
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 			
Lungs			
Abdomen			
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 			
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			
Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 			

* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA



Evaluación física previa a la participación: SOLO este formulario debe enviarse a la escuela para la participación atlética. El examen físico debe ser después del 7 de junio del año escolar de participación

Nombre del estudiante: _____ Grado: _____ Fecha de nacimiento: _____

DEPORTE: (rodea todo lo que corresponda) Baloncesto Fútbol

- Medicamento elegible para todos los deportes sin restricción.
- Medicamento elegible para todos los deportes sin restricción con recomendaciones para una evaluación adicional o tratamiento de _____
- Medicamento elegible para ciertos deportes. _____
- No es medicamento elegible en espera de una evaluación adicional.
- No es medicamento elegible para ningún deporte.

Recomendaciones: _____

He examinado al estudiante nombrado en este formulario y he completado la evaluación física previa a la participación. El atleta no tiene contraindicaciones clínicas aparentes para practicar y puede participar en el deporte (s) como se describe en este formulario. Una copia de los resultados del examen físico está registrada en mi oficina y puede ponerse a disposición de la escuela a petición de los padres. Si surgen condiciones después de que el atleta haya sido autorizado para participar, el médico puede rescindir la elegibilidad médica hasta que se resuelva el problema y se expliquen completamente las posibles consecuencias al atleta y a los padres o guardianes.

Nombre del profesional de la salud (versión impresa): _____ Fecha: _____

Dirección: _____ Teléfono: _____

Firma del profesional de la salud: _____, MD, DO, NP, or PA

***Fecha del examen:** _____

**La fecha del examen debe ser posterior al 7 de junio de la Año escolar de participación prevista.*

PHYSICIANS STAMP:

INFORMACIÓN DE EMERGENCIA COMPARTIDA (completada por el padre/guardián)

Alergias: _____

Medicamentos: _____

Otra información: _____

Contactos de emergencia: _____

Yo, _____, El padre / guardián del estudiante mencionado anteriormente atestigua que estas declaraciones son precisas a mi leal saber y entender.

Firma de los padres: _____ Fecha: _____