

Preparticipation Physical Evaluation Form

History form

(Note: Patients and parents must complete this form before the medical evaluation. It stays in the individual's medical file and is not sent to the athletic department.)

Name:

OSIS #:

Sex:

Age:

School:

Date of birth:

Date of exam:

Sport(s):

Please list all prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you carry an inhaler?

Yes

No

Do you carry an epi-pen?

Yes

No

Do you have any allergies?

Yes

No

If yes, identify specific allergy below:

Medicines

Pollens

Food

Stinging

Insects

Latex

Others:

General questions

Has a doctor ever denied or restricted your participation in sports for any reason?

Yes

No

Do you have any ongoing medical conditions?

Yes

No

If so, please identify below:

Asthma

Anemia

Diabetes

Infections

Sickle cell disease or trait

Other:

Have you ever been admitted to the hospital?

Yes

No

Have you ever had surgery?

Yes

No

Heart health questions		
Have you ever passed out or nearly passed out during or after exercise?	Yes	No
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	Yes	No
Does your heart ever race or skip beats while resting or during exercise?	Yes	No
Has a doctor ever told you that you have any heart problems?	Yes	No
If so, check all that apply:		
High blood pressure	A heart murmur	
High cholesterol	A heart infection	
Kawasaki disease	Other:	
Has a doctor ever ordered a test for your heart? (e.g., ECG/EKG, echocardiogram)	Yes	No
Do you get lightheaded or feel more short of breath than expected during exercise?	Yes	No
Do you get more tired or short of breath more quickly than your friends during exercise?	Yes	No
Have you ever had any heart surgery?	Yes	No
Does anyone in your family have an irregular heartbeat?	Yes	No
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 accidents, or sudden infant death syndrome)?	Yes	No
Does anyone in your family have a heart problem, pacemaker, or defibrillator?	Yes	No
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	Yes	No
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	Yes	No
Bone and joint questions		
Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?	Yes	No
Have you ever had any broken or fractured bones or dislocated joints?	Yes	No

Have you ever had an injury that required X-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	Yes	No
Have you ever had a stress fracture?	Yes	No
Have you ever been told that you have or had an x-ray for neck instability? (e.g., Down syndrome or dwarfism)	Yes	No
Do you regularly use a brace, orthotics, or other device?	Yes	No
Do you have a bone, muscle, or joint injury that bothers you?	Yes	No
Medical questions		
Do you have any history of juvenile arthritis or connective tissue disease?	Yes	No
Do any of your joints become painful, swollen, warm, or look red?	Yes	No
Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
Have you ever used an inhaler or taken asthma medicine?	Yes	No
Is there anyone in your family who has asthma?	Yes	No
Were you born without, or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	Yes	No
Do you have groin pain or a painful bulge or hernia in the groin area?	Yes	No
Have you had infectious mononucleosis (mono) within the last month?	Yes	No
Do you have any rashes, pressure sores, or other skin problems?	Yes	No
Have you had a herpes or MRSA skin infection?	Yes	No
Have you ever had a head injury or concussion?	Yes	No
Have you ever had an unexplained seizure?	Yes	No
Have you ever had a hit or blow to the head that caused confusion, long-lasting headaches, or memory problems?	Yes	No
Do you have a history of seizure disorder?	Yes	No
Do you have headaches with exercise?	Yes	No
Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Yes	No

Have you ever been unable to move your arms or legs after being hit or falling?	Yes	No
Have you ever become ill while exercising in the heat?	Yes	No
Do you get frequent muscle cramps when exercising?	Yes	No
Have you had any problems with your eyes or vision?	Yes	No
Have you had any eye injuries?	Yes	No
Do you wear glasses or contact lenses?	Yes	No
Do you wear protective eyewear, such as goggles or a face shield?	Yes	No
Have you ever had hearing loss or problems with your hearing?	Yes	No
Do you worry about your weight?	Yes	No
Are you trying to or has anyone recommended that you gain or lose weight?	Yes	No
Are you on a special diet or do you avoid certain types of foods?	Yes	No
Have you ever had an eating disorder?	Yes	No
Do you have any concerns that you would like to discuss with a doctor?	Yes	No
Do you have any other medical problems?	Yes	No
Females only		
Have you ever had a menstrual period?	Yes	No
Have you had any problems with your periods (e.g., severe cramps, heavy bleeding)?	Yes	No
When was your last period?		
What is the frequency of your periods?		
<p>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 _____ to have a physical examination, which will include an inguinal and testicular examination for boys and an inguinal examination for girls.</p> <p>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.</p>		
Parent /Guardian name and signature:		
Date:		
<p><i>Note: This form should be retained in the individual's medical file and is not to be returned to the athletic department.</i></p>		

Physical examination form			
	Yes	No	Notes
Do you feel safe at your home or residence?			
Do you feel safe at school?			
Do you ever feel stressed or under pressure?			
Do you feel sad, hopeless, depressed, or anxious?			
Have there been changes in your weight?			
Have you taken supplements to gain/lose weight or improve performance?			
Have you tried cigarettes, alcohol, or drugs?			
Have you taken anabolic steroids or other performance supplements?			
Do you wear a seat belt?			
Are you using contraceptives?			
Are you sexually active?			
In the past 30 days, did you use cigarettes, alcohol, or drugs?			
Examination			
Height:	Sex:	Male	Female
Weight:	BP:		
Pulse:	Vision: R20/	L20/	
Corrected: Yes No			
Medical	Normal	Abnormal findings	
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart (Murmurs, PMI, etc.)			
Pulses			
Lungs			
Abdomen			
Genitourinary (Males only)			
Skin (HSV, MRSA, Tinea corporis)			
Neurological			

Musculoskeletal	Normal	Abnormal findings
Neck		
Back (including Scoliosis)		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional (Duck-Walk, Hop)		
Provider information		
Name of medical provider:		
License/NPI number:		
Address:		
Phone:		
Signature:		

Disclaimer: The format of this document is adapted from the New York City Department of Education's Preparticipation Physical Evaluation form, available at <https://infohub.nyced.org/docs/default-source/default-document-library/preparticipation-physical-evaluation.pdf>.