PREPARTICIPATION PHYSICAL EVALUATION

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: Sex assigned at birth (F, M, or intersex):	Sport(s): How do you identify your gender? (F, M, or other):
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 ba	othered by any of	the following prob	lems? (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 [questior	ns 1 and 2, or que	stions 3 and 4] for scre	ening purposes.)

GEN (Exp Circl	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.					

	RT HEALTH QUESTIONS ABOUT YOU NTINUED)	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?		
HEA	RT 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 poly- morphic 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
to	lave you ever had a stress fracture or an injury o a bone, muscle, ligament, joint, or tendon that aused you to miss a practice or game?		
	Do you have a bone, muscle, ligament, or joint njury that bothers you?		
MEDIC	CAL QUESTIONS	Yes	No
	Do you cough, wheeze, or have difficulty preathing during or after exercise?		
	Are you missing a kidney, an eye, a testicle males), your spleen, or any other organ?		
	Do you have groin or testicle pain or a painful pulge or hernia in the groin area?		
n n	Do you have any recurring skin rashes or ashes that come and go, including herpes or nethicillin-resistant <i>Staphylococcus aureus</i> MRSA)?		
c	tave you had a concussion or head injury that aused confusion, a prolonged headache, or nemory problems?		
v to	Have you ever had numbness, had tingling, had veakness in your arms or legs, or been unable o move your arms or legs after being hit or alling?		
	Have you ever become ill while exercising in the neat?		
	Do you or does someone in your family have ickle cell trait or disease?		
	lave you ever had or do you have any prob- ems 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

PHYSICAL EXAMINATION FORM

Name: ____

PHYSICIAN REMINDERS

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).

EXAN	NINATION								
Height	t:			Weight:					
BP:	/	(/)	Pulse:	Vision: R 20/	L 20/	Correc	ted: 🗆 Y 🛛	
MEDI	CAL							NORMAL	ABNORMAL FINDINGS
	arfan stigme				ned palate, pectus excavatum, arac aortic insufficiency)	chnodactyly, hyper	laxity,		
	ears, nose, pils equal earing	and thre	pat						
Lymph	nodes								
Heartª ● Mu		cultation	standi	ng, auscultatio	on supine, and ± Valsalva maneuv	er)			
Lungs									
Abdor	men								
tin	ea corporis	x virus (HSV), I	esions sugges	tive of methicillin-resistant Staphylo	ococcus aureus (M	RSA), or		
	logical								
	CULOSKELE	AL						NORMAL	ABNORMAL FINDINGS
Neck									
Back									
Should	der and arm	1							
Elbow	and forear	n							
Wrist,	hand, and	fingers							
Hip ar	nd thigh								
Knee									
Leg ar	nd ankle								
Foot a	nd toes								
Function Do		iat test	single-	leg squat test,	and box drop or step drop test				
	dar alastras								
	of those.			CG), echocar	diography, referral to a cardiologi	st for abnormal ca	rdiac histo	ory or examin	ation findings, or a combi-
nation o	of those.	ardiogra	aphy (E		diography, referral to a cardiologi):				
nation o Name o Address	of those. of health ca s:	ardiogra re profes	aphy (E ssional	(print or type)				Dat	

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Date of birth: _____

PREPARTICIPATION PHYSICAL EVALUATION MEDICAL ELIGIBILITY FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION - ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD	D ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION
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Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last)		(First)	(Mid	dle Initial)	Date of Birth
Age Sex assigned at birth (F, M or intersex)	Grade	School		City	
Present Address				Telephone	
Medically eligible for all sports without restriction					
Medically eligible for all sports without restriction w	ith recommendat	tions for further evaluat	tion or treatment of		
□ Medically eligible for certain sports					
□ Not medically eligible pending further evaluation					
Not medically eligible for any sports					
Recommendations:					
oletely explained to the athlete (and parents/guardians	-				
SIGNATURE OF HEALTH CARE PROFESSIONAL (MD ()r do)/pa/apnp	*:			
Clinic Name					
Address/Clinic		City		State	Zip Code
Felephone			Date of Examination		
* PHYSICIANS may authorize Nurse Pr	ractitioners to starr	np this card with the phys	sician's signature or the name of the	eclinic with whick	n the physician is affiliated.
Parents' Place of Employment					
amily Physician		Fa	amily Dentist		
Name of Private Insurance Carrier			Те	elephone	
Subscriber Member Name (Primary Insured)					
Emergency Information					
Allergies					
Medications					
Other Information					
Immunizations D Up to date (see attached documen	tation) 🛛 Not	up to date - specify			
(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatit			,		
1. I hereby give my permission for the above named	student to practic	ce and compete and rep	resent the school in WIAA approve	a interscholastic	c sports except those restricted on this

2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.