CIF PRE-PARTICIPATION PHYSICAL EVALUATION: HISTORY FORM (TO BE RETAINED BY PHYSICIAN)

(This form is to be filled out by the parent/patient prior to seeing the physician. The physician should keep this it in the medical chart.)

Name_____ Date of Exam _____ School_____

Gender_____ Date of Birth_____ Grade_____ Sport(s)_____

Medicines and Allergies: Please list all the prescriptions and over-the-counter medicines and supplements (herbal and medicinal) that you are currently taking:

Do you have any allergies? ◻ Yes ◻ No If yes, please identify the specific allergy(ies): ◻ Pollens _____ ◻ Food _____ ◻ Medicines _____ ◻ Insects_____ ◻ Other _____

Explain 'yes' answers on the back of this page. Circle questions you don't know the answer 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? Identify: ◻ Asthma ◻ Anemia ◻ Diabetes ◻ Infections ◻ Other:		
3. Have you ever spent the night in a hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		
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: ◻ High blood pressure ◻ A heart murmur ◻ High cholesterol ◻ A heart infection ◻ Kawasaki disease ◻ Other		
9. Has a doctor ever ordered a test for your heart? (i.e. EKG/ECG, echocardiogram)		
10. Do you get light-headed 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		
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 hypertropic cardiomyopathy, Marfan syndrome, anthythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic centricular 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		
17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or 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 atlantoxial instability, Down syndrome or dwarfism?		
22. Do you regularly use a brace, orthotics or other assistive device?		
23. Do you have a bone/muscle/joint injury bothering 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		
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, n eye, a testicle (males), your spleen or any other organ?		
30. Do you have groin pain or painful bulge/hernia in the groin?		
31. Have you had infectious mononucleosis (mono) in 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 while 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 face shield?		
47. Do you worry about your weight?		
48. Are you trying 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 drink alcohol or use any prescription or over-the-counter or illegal drugs?		
52. Have you ever taken anabolic steroids or used any other supplement to gain or lose weight or improve performance?		
53. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
54. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of student_____ Signature of parent_____ Date_____

CLEARANCE FORM (TO BE SIGNED BY PHYSICIAN AND RETURNED TO ATHLETICS OFFICE

Physical Examination – *Please Print*

Student's Name: _____
Last First Middle

Address: _____
Street City Zip

Birth Date: _____ M / F Graduating Year_____ HS Attended Last Year: _____

Parent/Guardian Name: _____ Cell #:_____

Email Address: _____

To Be Completed by Physician:

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____/_____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

MEDICAL:	**Normal**	**Abnormal Findings**	**Initials**
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL:	**Normal**	**Abnormal Findings**	**Initials**
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Station-based examination only

CLEARANCE:

____ Cleared

____ Not Cleared for:_____ Reason: _____

____ Cleared after completing Evaluation/Rehabilitation for:_____

Evaluation/Rehabilitation Completed: _____
Physician's Signature Date

Final Clearance: _____
Original Examining Physician's Signature Date

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities. (Note exception above)

_____ **Phone #:** _____

_____

_____ _____

Physician's Name, Address (stamp or print) **Examiner's Signature DATE**

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Revised: 4/26/19