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: _____ **Sport(s):** _____

Sex assigned at birth (F/M/intersex): _____ **How do you identify your gender? (F/M/Non-binary/other):** _____

List past and current medical conditions: _____

_____

Have you ever had surgery? If yes, list all past surgical procedures and dates: _____

_____

Medicines and supplements: List all current prescriptions, inhalers, over the counter medications, and supplements (herbal/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	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied/restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness? (Asthma, diabetes, anemia, etc.)		
4. Do you use a rescue inhaler for any reason?		
5. Have you ever spent the night in the hospital?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
6. Have you ever passed out or nearly passed out during or after exercise?		
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
8. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
9. Has a doctor ever told you that you have any heart problems?		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
10. Has a doctor ever requested a test for your heart? (Electrocardiography (ECG) or echocardiography)		
11. Do you get light-headed or feel shorter of breath than your friends during exercise?		
12. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained death before age 35? (including drowning and unexplained car crash)		
14. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrythmogenic right ventricular cardio-myopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
15. Has anyone in your family had a pacemaker or implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
16. Have you ever had a fracture, stress fracture or an injury to a bone, muscle, ligament, joint or tendon?		
17. Have you ever had an injury that caused you to miss a practice or game?		
18. Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
19. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
20. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
21. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
22. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin resistant *Staphylococcus aureus (MRSA)?*		
23. Have you had a concussion or head injury that caused confusion, prolonged headache, or memory problems?		
24. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
25. Have you ever become ill while exercising in the heat?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
26. Do you or does someone in your family have sickle cell trait or disease?		
27. Have you ever had or do you have any problems with your eyes or vision?		
28. Do you worry about your weight?		
29. Are you trying or has anyone recommended that you gain or lose weight?		
30. Are you on a special diet or do you avoid certain types of foods or food groups?		
31. Have you ever had an eating disorder?		
MENSTRUAL QUESTIONS	**Yes**	**No**
32. Have you ever had a menstrual period?		
33. How old were you when you had your first menstrual period?		
34. When was your most recent menstrual period?		
35. How many periods have you had in the past 12 months?		

Explain any "Yes" answers with relevant dates:

_____

_____

_____

_____

_____

- - -

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/guardian (if athlete is under 18): _____

Date: _____

SUNY Cortland Athletic Training
Park Center, Room 1207 • P.O. Box 2000 • Cortland, NY 13045
Phone: (607) 753-4901

PREPARTICIPATION PHYSICAL EVALUATION - PHYSICAL EXAMINATION FORM

Name: _____ **Date of birth:** _____

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 on History Form)

EXAMINATION

Height: _____ **Weight:** _____ ☐ **Male** ☐ **Female**

BP: _____ / _____ (_____ / _____) **Pulse:** _____ **Vision: R 20/**_____ **L 20/**_____ **Corrected:** ☐ **Yes** ☐ **No**

MEDICAL	Normal	Abnormal Findings
Appearance - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes, ears, nose, and throat - Pupils equal - Hearing		
Lymph Nodes		
Heart[1] - Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporus		
Neurological		
Genitourinary (males only)		
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 - Double-leg squat test, single-leg squat test, and box drop or step drop test		

[1]Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of these

☐ **Cleared for intercollegiate sports without restriction** ☐ **Not cleared for sports participation. Reason for denial:** _____

Name of healthcare professional (print or type): _____ **Date:** _____

Address: _____ **Phone:** _____

Signature of healthcare professional: _____, MD, DO, NP, or PA

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