ATHLETIC PREPARTICIPATION PHYSICAL EVALUATION

STUDENT HISTORY FORM **Date of Exam** _____

(Note: This form is to be filled out by the student (and/or parents if student is under age 18) prior to seeing the provider.

Name _____ Date of Birth _____

Sex _____ Age _____ Year _____ Sport(s) (If applicable) _____

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

_____

Do you have any allergies? ❑ Yes ❑ No If yes, please identify specific allergy: ❑ Medicines ❑ Pollens ❑ Food ❑ Stinging insects

Explain "Yes" answers below, Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: ❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race of skip beats (irregular beats) during exercise?			33. Have you had herpes or MRSA skin infection?		
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: _____			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?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram?			36. Do you have a seizure disorder?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			37. Do you have headaches with exercise?		
11. Have you ever had an unexplained seizure?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			39. Have you ever been unable to move your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**	40. Have you ever become ill while exercising in the heat?		
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)?			41. Do you get frequent muscle cramps when exercising?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT ayndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?			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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			44. Have you had any eye injuries?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			45. Do you wear glasses or contact lenses?		
BONE AND JOINT QUESTIONS	**YES**	**NO**	46. Do you wear protective eyewear, such as goggles or a face shield?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			47. Do you worry about your weight?		
18. Have you ever had any broken or fractured bones or dislocated joints?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			49. Are you on a special diet or do you avoid certain types of foods?		
20. Have you ever had a stress fracture?			50. Have you ever had an eating disorder?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			51. Do you have any concerns that you would like to discuss with a doctor?		
22. Do you regularly use a brace, orthotics, or other assistive device?			**FEMALES ONLY**		
23. Do you have a bone, muscle, or joint injury that bothers you?			52. Have you ever had a menstrual period?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			53. How old were you when you had your first menstrual period?		
25. Do you have any history of juvenile arthritis or connective tissue disease?			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here: _____

_____

_____

_____

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/guardian_____ Date_____
(if student is under age 18)

***Must be Reviewed by Provider*-Provider Name:** _____ **Provider Signature:**_____ **Date:**_____

Cal Maritime Athletic Pre-participation Physical Exam

Name_____ Sport_____ Date _____

Age _____ Date of Birth _____ Year in school _____ Contact Phone Number _____

Ht_____ Wt_____ BP_____ HR_____ Vision (R)_____(L)_____

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/Ears/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

CLEARANCE

☐ **Cleared**

☐ **Cleared after completing evaluation / rehabilitation for:** _____

_____

_____

☐ **Not Cleared for**: _____

Recommendations: _____

_____

_____

Name of Physician (print) _____ **Date**: _____

Address _____ **Phone** _____

Signature of physician _____

Original – Health Center Duplicate – Athletic Training