



Ohio High School Athletic Association Preparticipation Physical Evaluation



DATE OF EXAM: _____

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Name _____ Sex _____ Age _____ Date of Birth _____
 Grade _____ School _____ Sport(s) _____
 Address _____ Phone _____
 Personal Physician _____
 In case of emergency, contact: Name _____ Relationship _____
 Phone (H) _____ (W) _____ (Cell) _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

- | | | | | | | | | | | | | | | | | | |
|---|------------|----------|-----------|-----------|-----------|----------------|----------------|-------|------------|------------|-----|-------|------|-----------|-------|-------------|--|
| <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you think you are in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Has a doctor ever told you that you have (check all that apply):
 <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur
 <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A heart infection</p> <p>11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:
 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:
 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:
 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 2px;">Head</td> <td style="padding: 2px;">Neck</td> <td style="padding: 2px;">Shoulder</td> <td style="padding: 2px;">Upper Arm</td> <td style="padding: 2px;">Elbow</td> <td style="padding: 2px;">Forearm</td> <td style="padding: 2px;">Hand / Fingers</td> <td style="padding: 2px;">Chest</td> </tr> <tr> <td style="padding: 2px;">Upper back</td> <td style="padding: 2px;">Lower back</td> <td style="padding: 2px;">Hip</td> <td style="padding: 2px;">Thigh</td> <td style="padding: 2px;">Knee</td> <td style="padding: 2px;">Calf/shin</td> <td style="padding: 2px;">Ankle</td> <td style="padding: 2px;">Foot / Toes</td> </tr> </table> <p>21. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Hand / Fingers | Chest | Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot / Toes | <p>25. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Have you had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Do you have headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you happy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>47. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. Record the dates of your most recent immunizations (shots)
 Tdap _____ MMR _____ Hepatitis B _____
 Chicken Pox _____ Meningococcal _____</p> <p style="text-align: center;">FEMALES ONLY</p> <p>49. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>50. How old were you when you had your first menstrual period? _____</p> <p>51. How many periods have you had in the last 12 months? _____</p> <p>Explain "Yes" Answers Here: (Attach additional sheets as needed)

 _____</p> |
| Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Hand / Fingers | Chest | | | | | | | | | | |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot / Toes | | | | | | | | | | |

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: _____ Date: _____
Athlete Parent or Guardian (If athlete is under 18)

The student has family insurance Yes No; If yes, family insurance company name and policy number: _____

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.
 NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004. Rev. 03/10

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name _____ Birth Date _____

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

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

Follow-Up Questions on More Sensitive Issues (Optional)

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrb/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: _____

MEDICAL	Normal	Abnormal findings	Initials*
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

Notes: _____

Clearance

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: _____

Not cleared for: All Sports Certain sports: _____ Reason: _____

Recommendations: _____

Emergency Information:

Allergies: _____

Other Information: _____

Name of Physician: (print/type/stamp) _____ (M.D., D.O., D.C.) 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: _____

Address: _____ Phone: _____

Signature of Physician: _____