PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form and bring it to your appointment.

Name: _____ Date of birth: _____ Sport: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ 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 (i.e., medicines, pollens, food, stinging insects) **AND** reactions:

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
1.	Feeling nervous, anxious, or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Little interest or pleasure in doing things	0	1	2	3
4.	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

(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)

1.	Do you have any concerns that you would like to discuss with your provider?	Yes	No
2.	Has a provider ever denied or restricted your participation in sports for any reason?	Yes	No
3.	Do you have any ongoing medical issues or recent illness?	Yes	No

HEART HEALTH QUESTIONS ABOUT YOU

4.	Have you ever passed out or nearly passed out during or after exercise?	Yes	No
5.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	Yes	No
6.	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	Yes	No
7.	Has a doctor ever told your that you have any heart problems? (i.e., heart murmur, arrythmia, cardiomyopathy, long QT syndrome)	Yes	No
8.	Has a doctor ever requested a test for your heart? (i.e., electrocardiography (ECG) or echocardiography)	Yes	No
9.	Do you get light-headed or feel shorter of breath than your friends during exercise?	Yes	No
10.	Have you ever had a seizure?	Yes	No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

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)?	Yes	No

Name: _____ Date of birth: _____ Sport: _____

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 polymorphic ventricular tachycardia (CPVY)?	Yes	No
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	Yes	No

BONE AND JOINT QUESTIONS

14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, tendon that caused you to miss a practice or game?	Yes	No
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	Yes	No

MEDICAL QUESTIONS

16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?	Yes	No
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	Yes	No
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resident *Staphylococcus aureus* (MRSA)?	Yes	No
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? If yes, please include date(s). _____	Yes	No
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	Yes	No
	Yes	No
22. Have you ever become ill while exercising in the heat?	Yes	No
23. Do you or does someone in your family have sickle cell trait or disease?	Yes	No
24. Have you ever had or do you have any problems with your eyes or vision?	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?	Yes	No
27. Are you on a special diet or do you avoid certain types of foods or food groups?	Yes	No
28. Have you ever had an eating disorder?	Yes	No

If applicable, please answer below. If not applicable, check here [ ]

29. Have you ever had a menstrual period?	Yes	No
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: _____

33. I give permission to Health Services and SUNY Oswego Athletics to share medical information as it relates to athletic participation.	Yes	No

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 Date

***REQUIRED:**
I have reviewed this completed History Form.

Signature of Healthcare Provider Date

Modified from "Preparticipation Physical Evaluation Form."

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____ Sport: _____

PROVIDER REMINDERS

- Review and sign History Form.

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?

EXAMINATION

Height: _____ Weight: _____

BP: / (/) Pulse: _____ Vision: R 20/____ L 20/____ Corrected: [ ] Y [ ] N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)	[ ]	[ ]
Eye, ears, nose, and throat		
• Pupils equal	[ ]	[ ]
• Hearing	[ ]	[ ]
Lymph nodes	[ ]	[ ]
Heart*		
*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.		
• 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 corporis	[ ]	[ ]
Neurological	[ ]	[ ]

MUSCULOSKELETAL		
Neck	[ ]	[ ]
Back	[ ]	[ ]
Shoulder and arm	[ ]	[ ]
Elbow and forearm	[ ]	[ ]
Wrist, hand, fingers	[ ]	[ ]
Hip and thigh	[ ]	[ ]
Knee	[ ]	[ ]
Leg and ankle	[ ]	[ ]
Foot and toes	[ ]	[ ]
Functional		
• Double-leg squat test, single-leg squat test, duck walk	[ ]	[ ]

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____ Sport: _____

SICKLE CELL STATEMENT

Starting August 1, 2022, all NCAA student athletes will be required to submit the **results** of a Sickle Cell Trait (SCT) blood test. This will only need to be submitted one time for the entirety of the athlete's college career. Until these results are submitted, the athlete will not be cleared to participate. Results can either be a copy of a sickle cell solubility test or a copy of a newborn screening test.

MEDICAL ELIGIBILITY

[ ] Medically eligible for all sports without restriction

[ ] Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of:

_____

_____

[ ] Medically eligible for certain sports:

_____

_____

[ ] Not medically eligible pending further evaluation

[ ] Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. A copy of the physical examination findings is on record in my office and can be made available upon request. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete.

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

Address: _____ Phone: _____

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

Modified from "Preparticipation Physical Evaluation Form."