■ 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, 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	(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 (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
Do you have any concerns that you would like to discuss with your provider?		
Has a provider ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
Have you ever passed out or nearly passed out during or after exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
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)?		
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 (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS		机带性系统
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or 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?		
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	1100000000000	
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		967
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
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?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any prob- lems with your eyes or vision?		1

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
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		

Explain	Explain "Yes" answers here.					

COVID-19

- A current physical MUST be on file. CHSAA recommends this PPE form.
 - o COVID-19 specific questions should be included in the physical screening to include:
 - 1. Have you tested positive for COVID-19?
 - 2. Have you had any known exposure to a COVID-19 positive individual?
 - 3. Have you been tested for COVID-19?
 - 4. Have you had any new onset of cough or shortness of breath?
 - 5. Have you experienced any recent temperature greater than 100.3°
 - The most recent medical evidence recommends consideration of cardiac testing if a student athlete has
 previously tested positive for COVID-19. This should be discussed with the team physician on a case-by-case
 basis.

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 or guardian:	
Date:	
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