# **DuBois Integrity Academy**

Athletics Dept. | 6504 Church St, Riverdale, GA 30274



## ■ PREPARTICIPATION PHYSICAL EVALUATION

## **HISTORY FORM**

Note: Complete and sign this form (with your parent	ts if younger than 1	8) before your ap	pointment.					
Name: Date of birth:								
Date of examination:	Sport(s):	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 surgi	cal procedures.							
Medicines and supplements: List all current prescri	ptions, over-the-co	unter medicines, a	nd supplements (herbal	and nutritional).				
Do you have any allergies? If yes, please list all yo	ur allergies (ie, me	dicines, pollens, fo	ood, stinging insects).					
Patient Health Questionnaire Version 4 (PHQ-4)								
Over the last 2 weeks, how often have you been b	othered by any of	the following prob	lems? (check box next to	appropriate number)				
	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  $\geq$ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GEN (Exp Circ	Yes	No	
1.	Do you have any concerns that you would like to discuss with your provider?		
2.	Has a provider ever denied or restricted your participation in sports for any reason?		
3.	Do you have any ongoing medical issues or recent illness?		
HEA	RT HEALTH QUESTIONS ABOUT YOU	Yes	No
4.	Have you ever passed out or nearly passed out during or after exercise?		
5.	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?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

	RT HEALTH QUESTIONS ABOUT YOU NTINUED)	Yes	No
9.	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10.	Have you ever had a seizure?		
HEA	RT 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?		

14.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that			25. Do you worry about your weight?		
	caused you to miss a practice or game?			26. Are you trying to or has anyone recommended that you gain or lose weight?		
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?		
MEI	DICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMALES ONLY	Yes	No
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			29. Have you ever had a menstrual period?  30. How old were you when you had your first menstrual period?		<u> </u>
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			31. When was your most recent menstrual period?		
19.	Do you have any recurring skin rashes or			32. How many periods have you had in the past 12 months?		
	rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			Explain "Yes" answers here.		
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?					

Yes No

**BONE AND JOINT QUESTIONS** 

Date: \_

MEDICAL QUESTIONS (CONTINUED)

Yes No

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#### 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 of History Form).

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BP:	/	(	/	)	Pulse:		Vision: R 20/		L 20/	Corre	cted: 🗆 Y	□N	
MEDI	CAL										NORMAL	ABNORMA	AL FINDINGS
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	ears, no pils equa earing		throa	t									
Lymph	nodes												
Heart <sup>o</sup> • Mu		ausculta	ation s	tandir	ng, auscultatio	on supine, an	d ± Valsalva m	aneuver)					
Lungs													
Abdor	men												
	erpes sim		rus (H	SV), le	esions suggest	tive of methic	illin-resistant <i>St</i>	aphylococc	us aureus (M	RSA), or			
Neuro	logical												
MUSC	CULOSK	ELETAL									NORMAL	ABNORMA	AL FINDINGS
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Back													
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#### PREPARTICIPATION PHYSICAL EVALUATION

# **MEDICAL ELIGIBILITY FORM** Date of birth: \_\_\_\_\_ Name: ☐ 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 $\square$ Not medically eligible for any sports Recommendations: I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. 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 (and parents or guardians). Address: Phone: Signature of health care professional: , MD, DO, NP, or PA SHARED EMERGENCY INFORMATION Allergies: \_\_\_\_ Medications: Other information: \_\_\_\_\_ Emergency contacts: \_\_\_\_

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