PREPARTICIPATION PHYSICAL EVALUATION Sport(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY FORM** (Note: Complete and sign this form (with your parents if younger than 18) before your appointment.)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex assigned at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 of your allergies (i.e., 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? (check box next to appropriate number)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several days | Over half the days | Nearly every day |
| Feeling nervous, anxious, or on edge |  |  |  |  |
| Not being able to stop or control worrying |  |  |  |  |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed, or hopeless |  |  |  |  |

(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 answers.) | 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 illnesses? |  |  |
| HEART 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. |  |  |
| 9. Do you ever 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 or short QT syndrome (LQTC or SQTC), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)? |  |  |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before the age 35? HEALTH QUESTIONS (ABOUT YOUR FAMILY) |  |  |

|  |  |  |
| --- | --- | --- |
| BONES AND JOINT QUESTIONS | Yes | No |
| 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? |  |  |
| 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? |  |  |
| 17. Are you missing a kidney, an eye, a testicle (male), a spleen, or any other organ? |  |  |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? |  |  |
| 19. Do you have any recurring skin rashes or rashes that come & go, including herpes or |  |  |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? |  |  |
| 21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms & legs after being hit or fallen? |  |  |
| 22. Have you ever become ill while exercising in the heat? |  |  |
| 23. Do you or someone in your family have sickle cell trait or disease? |  |  |
| 24. Have you ever had or do you have any problems with your eyes or vision? |  |  |
| 25. Do you worry about your weight? |  |  |
| 26. Are you trying to or has anyone ever 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? |  |  |

**Explain “Yes” answers here. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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