This form should be placed into the athlete's medical file and should not be shared with schools or sports organizations.

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

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	Il procedures.
Medicines and supplements: List all current prescript	ions, over-the-counter medicines, and supplements (herbal and nutritional).
Do you have any allergies? If yes, please list all your	r allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been both	thered by any of t	he following proble	ems? (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	I	2	3
Little interest or pleasure in doing things	0	I	2	3
Feeling down, depressed, or hopeless	0	I	2	3
(A sum of $>$ 3 is considered positive on either	subscale [question	ns I and 2, or ques	stions 3 and 4] for scree	ening 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?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
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
9. 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)?		
Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

ONE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED)	Yes
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? 26. Are you trying to or has anyone recommended	
caused you to miss a practice or game? Oo you have a bone, muscle, ligament, or joint			that you gain or lose weight? 27. Are you on a special diet or do you avoid	
injury that bothers you?	Yes	No	certain types of foods or food groups?	
Do you cough, wheeze, or have difficulty breathing during or after exercise?	100		28. Have you ever had an eating disorder? FEMALES ONLY	Yes
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?	
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?	
Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			32. How many periods have you had in the past 12 months? Explain "Yes" answers here.	
Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?				
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?				
. Have you ever become ill while exercising in the				

No

No

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Signature of athlete:

Signature of parent or guardian: