



Ohio High School Athletic Association

Preparticipation Physical Evaluation



DATE OF EXAM: _____

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Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact: Name _____ Relationship _____

Phone (H) _____ (W) _____ (Cell) _____ (Cell) _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No
2. Do you have an ongoing medical condition (like diabetes or asthma)?
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?
4. Do you have allergies to medicines, pollens, foods, or stinging insects?
5. Do you think you are in good health?
6. Have you ever passed out or nearly passed out DURING exercise?
7. Have you ever passed out or nearly passed out AFTER exercise?
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?
9. Does your heart race or skip beats during exercise?
10. Has a doctor ever told you that you have (check all that apply):
 High Blood Pressure A heart murmur
 High Cholesterol A heart infection
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)
12. Has anyone in your family died for no apparent reason?
13. Does anyone in your family have a heart problem?
14. Has any family member or relative died of heart problems or of sudden death before age 50?
15. Does anyone in your family have Marfan syndrome?
16. Have you ever spent the night in a hospital?
17. Have you ever had surgery?
18. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand / Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / Toes
19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:

25. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No
 26. Is there anyone in your family who has asthma?
 27. Have you ever used an inhaler or taken asthma medicine?
 28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
 29. Have you had infectious mononucleosis (mono) within the last month?
 30. Do you have any rashes, pressure sores, or other skin problems?
 31. Have you had a herpes skin infection?
 32. Have you ever had a head injury or concussion?
 33. Have you been hit in the head and been confused or lost your memory?
 34. Have you ever had a seizure?
 35. Do you have headaches with exercise?
 36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
 37. Have you ever been unable to move your arms or legs after being hit or falling?
 38. When exercising in the heat, do you have severe muscle cramps or become ill?
 39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
 40. Have you had any problems with your eyes or vision?
 41. Do you wear glasses or contact lenses?
 42. Do you wear protective eyewear, such as goggles or a face shield?
 43. Are you happy with your weight?
 44. Are you trying to gain or lose weight?
 45. Has anyone recommended you change your weight or eating habits?
 46. Do you limit or carefully control what you eat?
 47. Do you have any concerns that you would like to discuss with a doctor?
- FEMALES ONLY**
48. Have you ever had a menstrual period?
 49. How old were you when you had your first menstrual period? _____
 50. How many periods have you had in the last 12 months? _____

Explain "Yes" Answers Here: (Attach additional sheets as needed)

21. Have you ever had a stress fracture?
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
23. Do you regularly use a brace or assistive device?
24. Has a doctor ever told you that you have asthma or allergies?

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: _____ Signature: _____ Date: _____

Athlete Parent or Guardian (If athlete is under 18)

The student has family insurance Yes No; if yes, family insurance company name and policy number: _____

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.
 NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION