Ohio High School Athletic Association
Preparticipation Physical Evaluation

DATE OF EXAM: ____

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

This section must 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.

Name ____________________________ Sex _______ Age _______ Date of Birth _________
Grade ____ School _________________ Sport(s) ____________________________________

Question	
1. Has a doctor ever denied or restricted you Participation in sports for any reason?	
2. Do you have any ongoing medical condition (Like diabetes or asthma)?	
3. Are you currently taking any prescriptions 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 sudden death before the age of 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. 18. Have you ever had an injury, like a sprain, muscle or ligament tear? Tendonitis, which caused you to miss a practice or a game? If yes, circle Affected area below:	Head Neck Shoulder Upper Arm Elbow Forearm
19. Have you ever broken or fractured bones or dislocated joints? If yes, Circle below:	Hand/fingers Chest Upper back Lower Back
20. Have you had a bone or join injury that required x-rays, MRI, CT, surgery Injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes Circle below:	Hip Thigh Knee Calf/shin Ankle Foot/Toes
21. Have you ever had a stress Fracture?	
22. Have you been told that you have or have 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?	
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	
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 or are you missing a kidney, an eye, a testicle or any other organ?	
29. Have you ever had infectious mononucleosis (mono) within the Last month?	
30. Do you have any rashes, pressure sores, or other skin problems?	
31. Have you ever had a herpes infection?	
32. Do you wear glasses or contact lenses?	
33. Have you ever had a head injury or concussion?	
34. Have you ever been hit in the head and been confused or lost your memory?	
35. Have you ever had a seizure?	
36. Do you have headaches with exercise?	
37. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	
38. Have you ever been unable to move your arms or legs after being hit or falling?	
39. When exercising in the heat, do you have severe muscle cramps or become ill	

Explain yes answers (attach additional sheets as needed)

____
____
____
____

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

Signature: ___________________ Signature: _____________________ Date: ___
Athlete Parent or guardian (if athlete under 18)

The student has family insurance □ yes □ no; if yes, family insurance company name and policy number ____

NOTE: CONSENT AND HIPAA FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON SPERATE SHEET

NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION

Modified from American academy of family physicians, American academy of pediatrics, American college of sports medicine, American medical society fir sports medicine, American orthopedic society for sports medicine, and American osteopathic academy of sports medicine, 2004. Rev. 03/06

Student's name______________________ Birth Date ____________________________

Height ____ Weight _____ % Body Fat (optional) ______ Pulse______

BP _____/_____, _____/_____, _____/_____

Vision R 20/________ L 20/________ Corrected: Y N Pupils: Equal/Unequal

Follow-Up Questions on more sensitive issues (optional)

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you ever use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroids pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from youth Risk behavior Survey (Http//:www.cdc.gov/health/Youth/yrbs/index.htm) on guns seat belts, unprotected sex, domestic violence, drugs, etc?

Notes____
____
____

Medical	Normal	Abnormal Findings	Initials
Appearance			

Eyes/ears/nose/throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (male only)			
Skin			
Musculoskeletal	**Normal**	**Abnormal Findings**	**Initials**
Neck			
Back			
Shoulder/arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Multiple-Examiner set up only
Notes: ____
____

Clearance

☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for: ___________
____
____

☐ Not cleared for: ☐ All Sports ☐ Certain Sports: ___________ Reason: ____________
Recommendations: ____
____
____
____

Emergency Information:

Allergies: ____
Other Information: ____
Name of Physician: (print/type/stamp) ______________________________ M.D., D.O., D.C.) Date: _____________________
If the physicians assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) preformed the exam, name and address of collaborating physician or physician group:
Address: _______________________________ Phone: ___________________________
Signature of Physician: ____