Lake Washington School District

Pre-participation Physical Examination – Medical History Form

Name _____ Date of BIRTH _____ Date of EXAM _____

Gender: M F Age _____ Grade _____ Intended Sport(s) _____

Medications: Please list **ALL** prescription and over-the-counter medications, supplements (herbal and nutritional) and vitamins that you are currently taking.

_____

_____

_____

Please indicate what allergies you have:

□ None □ Pollens □ Stinging Insects (specify) _____ □ Foods (specify)_____ □ Medications (specify)_____

Explain all "YES" answers below. Circle questions that you don't know the answer to.

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please specify below: □ Asthma □ Anemia □ Diabetes □ Infections □ Other: _____		
3. Have you ever spent a night in the hospital?		
4. Have you ever had surgery?		
5. Have you had an injury or illness since your last physical exam?		
6. Are you currently injured or ill, or recovering from a recent injury/illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
7. Have you passed out or nearly passed out DURING or AFTER exercise?		
8. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
9. Does your heart ever race or skip beats (irregular beats) during exercise?		
10. Has a doctor ever told you that YOU have heart problem? If so, check all that apply: □ High Blood Pressure □ A heart murmur □ High Cholesterol □ A heart infection □ Kawasaki Disease Other: _____		
11. Has a doctor ever ordered a test for your heart, such as an ECG/EKG or an echocardiogram?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergenic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a PE class, a practice, or a game?		
18. Have you ever had any fractured or broken bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told you have (or had an x-ray for) for neck instability or atlantoaxis instability?		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have a history of juvenile arthritis of connective tissue disease?		

MEDICAL QUESTIONS	YES	NO
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without (or are you now missing) a kidney, an eye, a testicle, your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in your groin area?		
31. Have you had infectious mononucleosis (mono) within the last two months?		
32. Have you ever had a skin infection such as ringworm, MRSA, herpes, impetigo, etc?		
33. Have you ever had a head injury or a concussion?		
34. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
35. Do you have a history of seizure disorder?		
36. Do you have headaches with exercise?		
37. Have you ever had numbness or tingling 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. Have you ever become ill while exercising in the heat?		
40. Do you get frequent muscle cramps when exercising?		
41. Do you or someone in your family have sickle cell trait or disease?		
42. Have you had any problems with your eyes or vision?		
43. Have you had any eye injuries?		
44. Do you wear contact lenses or glasses?		
45. Do you wear protective eyewear, such as goggles or a face shield?		
46. Do you worry about your weight?		
47. Are you on a special diet or do you avoid certain types of foods?		
48. Are you trying to (or has someone recommended that you) lose weight or gain weight?		
49. Have you ever had an eating disorder?		
50. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**YES**	**NO**
51. Have you ever had a menstrual period?		
52. How old were you when you had your first menstrual period?		
53. How many periods have you had in the last 12 months?		

Explain all "YES" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parents are responsible for coordinating with their child's coach if their child has a life threatening health condition where they may need emergency medication i.e. EpiPen or inhaler during any sporting events they are participating in.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete_____ Signature of parent/guardian _____ Date_____

Lake Washington School District

Pre-participation Physical Examination – Physician Evaluation 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 feel safe at your home or residence?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Do you wear a seat belt?
2. **Consider reviewing questions on cardiovascular symptoms (questions 5-14).**

EXAMINATION		
Height	Weight	☐ Male ☐ Female
BP / (/)	Pulse	Vision R 20/ L 20/ Corrected ☐ Y
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
☐ Not cleared
  ☐ Pending further evaluation
  ☐ For any sports
  ☐ For certain sports _____

Reason _____

Recommendations _____

I have TODAY examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO