This form should be placed into the athlete's medical file and should **not** be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

## ■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance) HISTORY FORM

Date of examination: Sport(s):    ex assigned at birth (F, M, or intersex): How do you identify your gender? (F, M, non-binary, or another gender): Have you had COVID-19? (check one): Y N   f yes, have you had: One shot No shots Desired and current medical conditions;   Three shots Desoster date(s)	Note: Complete and sign this form (with your parer Name:			te of birth:	The state of the s
Have you had COVID-19? (check one):		•			
Have you been immunized for COVID-19? (check one):	Sex assigned at birth (F, M, or intersex):	How do you identil	y your gender? (F,	M, non-binary, or anoth	ner gender):
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 your allergies (ie, 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? (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 1 2 3  Little interest or pleasure in doing things 0 1 2 3  Feeling down, depressed, or hopeless 0 1 2 3	Have you had COVID-19? (check one): □ Y □	1 N			
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 your allergies (ie, 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? (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 1 2 3  Little interest or pleasure in doing things 0 1 2 3  Feeling down, depressed, or hopeless 0 1 2 3	Have you been immunized for COVID-19? (check	one): □Y □N			
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 your allergies (ie, 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? (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 1 2 3  Little interest or pleasure in doing things 0 1 2 3  Feeling down, depressed, or hopeless 0 1 2 3	List past and current medical conditions;				
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Over the last 2 weeks, how often have you been bothered by any of the following problems? (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 1 2 3  Little interest or pleasure in doing things 0 1 2 3  Feeling down, depressed, or hopeless 0 1 2 3	Do you have any allergies? If yes, please list all yo	our allergies (ie, me	dicines, pollens, fo	od, stinging insects).	
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Feeling nervous, anxious, or on edge 0 1 2 3 Not being able to stop or control worrying 0 1 2 3 Little interest or pleasure in doing things 0 1 2 3 Feeling down, depressed, or hopeless 0 1 2 3		bothered by any of	the following prob	lome? (Cirola rasmansa	ŀ
Feeling nervous, anxious, or on edge 0 1 2 3 Not being able to stop or control worrying 0 1 2 3 Little interest or pleasure in doing things 0 1 2 3 Feeling down, depressed, or hopeless 0 1 2 3	ordina lasi z wasis, now onen nave you been t			•	
Not being able to stop or control worrying 0 1 2 3 Little interest or pleasure in doing things 0 1 2 3 Feeling down, depressed, or hopeless 0 1 2 3	Feeling nervous, anxious, or on edge		1	2	
Feeling down, depressed, or hopeless 0 1 2 3		0	1	2	3
- · · · · · · · · · · · · · · · · · · ·	Little interest or pleasure in doing things	0	1	2	3
(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)	Feeling down, depressed, or hopeless	0	1	2	3
	(A sum of ≥3 is considered positive on either	r subscale [question	s 1 and 2, or ques	tions 3 and 4] for scree	ening purposes.)

(Exp	IERAL QUESTIONS Ilain "Yes" answers at the end of this form. Circle stions if you don't know the answer.)	Yes	Na
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 illness?		
HEA	RT 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.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
<ol><li>Do you get light-headed or feel shorter of breath than your friends during exercise?</li></ol>	1		
10. Have you ever had a seizure?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY U	Insure	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)?			-
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	1		

BON	IE AND JOINT QUESTIONS	Yes	No	MEDICA
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?			25. Do 26. Are you
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Ar
MED	ICAL QUESTIONS	Yes	Nσ	28. Ha
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?			MENSTR
1 <b>7</b> .	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?			30. Ho
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			31. W
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			explain
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
21.	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?			
22.	Have you ever become ill while exercising in the heat?			***************************************
23.	Do you or does 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?			

Do you worry about your weight?			
		1	
Are you trying to or has anyone recommend you gain or lose weight?	led that		
Are you on a special diet or do you avoid o ypes of foods or food groups?	ertain		
Have you ever had an eating disorder?			
STRUAL QUESTIONS	N/A	Yes	No
Have you ever had a menstrual period?			
How old were you when you had your first i period?	menstrual		
When was your most recent menstrual perio	qŝ		
How many periods have you had in the pas months?	t 12		
	you gain or lose weight?  Are you on a special diet or do you avoid of ypes of foods or food groups?  Have you ever had an eating disorder?  SIRUAL QUESTIONS  Have you ever had a menstrual period?  How old were you when you had your first to period?  When was your most recent menstrual period.  How many periods have you had in the pass	you gain or lose weight?  Are you on a special diet or do you avoid certain ypes of foods or food groups?  Have you ever had an eating disorder?  SIRUAL QUESTIONS  N/A  Have you ever had a menstrual period?  How old were you when you had your first menstrual period?  When was your most recent menstrual period?  How many periods have you had in the past 12	Are you on a special diet or do you avoid certain ypes of foods or food groups?  Have you ever had an eating disorder?  FIRUAL QUESTIONS  Have you ever had a menstrual period?  How old were you when you had your first menstrual period?  When was your most recent menstrual period?  How many periods have you had in the past 12

Explain "Yes" a	inswers nere	<b>7</b>	 

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:	· · · · · · · · · · · · · · · · · · ·
Signature of parent or guardian:	
Date:	

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Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

## ■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance) PHYSICAL EXAMINATION FORM

Signature of health care professional:

Name:		Date	of birth:	
PHYSICIAN REMINDERS  1. Consider additional questions on more-sensitive i  Do you feel stressed out or under a lot of pres  Do you ever feel sad, hopeless, depressed, or  Do you feel safe at your home or residence?  Have you ever tried cigarettes, e-cigarettes, d  During the past 30 days, did you use chewing  Do you drink alcohol or use any other drugs?  Have you ever taken anabolic steroids or used  Have you ever taken any supplements to help  Do you wear a seat belt, use a helmet, and used.  Consider reviewing questions on cardiovascular services.	sure? - anxious? - hewing tobacco, snuff, or dip g tobacco, snuff, or dip? d any other performance-enh you gain or lose weight or in se condoms?	ancing supplement? nprove your perform	ance?	
EXAMINATION				
Height: Weight:				"
BP: / ( / ) Pulse:	Vision: R 20/	L 20/	Corrected: □Y	□N
COVID-19 VACCINE		,		
Previously received COVID-19 vaccine:				•
Administered COVID-19 vaccine at this visit:   Y		☐ Second dose ☐ T	hird dose □ Boos	ter date(s)
MEDICAL			NORMAL	
Appearance     Marfan stigmata (kyphoscoliosis, high-arched pal myopia, mitral valve prolapse [MVP], and aortic in the control of the co		nnodactyly, hyperlaxi		
Eyes, ears, nose, and throat  Pupils equal  Hearing				
Lymph nodes				
Heart <sup>a</sup> • Murmurs (auscultation standing, auscultation supi	ine, and ± Valsalva maneuve	-)		
Lungs .			·	
Abdomen				
Skin  Herpes simplex virus (HSV), lesions suggestive of tinea corporis	methicillin-resistant Staphylo	coccus aureus (MRSA	), or	
Neurological				
MUSCULOSKELETAL			NORMAL	ABNORMAL FINDINGS
Neck				
Back				
Shoulder and arm				
Elbow and forearm				
Wrist, hand, and fingers				
Hip and thigh				
Knee				
Leg and ankle				
Foot and toes				
Functional  Double-leg squat test, single-leg squat test, and be	ox drop or step drop test			
Consider electrocardiography (ECG), echocardiography (ECG), echocardiogra		for abnormal cardia	c history or exami	nation findings, or a combi-
Name of health care professional (print or type):			Do	ite:
Address:			Phone:	

, MD, DO, NP, or PA

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