

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____
(First Name) (Last Name)

Date of examination: _____ Sport(s): _____

Sex assigned at birth: _____

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? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

(First Name)

(Last Name)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)			Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>		
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>		
HEART HEALTH QUESTIONS ABOUT YOU			Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)			Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>		
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)?	<input type="checkbox"/>	<input type="checkbox"/>		
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)?	<input type="checkbox"/>	<input type="checkbox"/>		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>		

