UC Davis 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: _____
Student ID: _____
Sex assigned at birth (F, M or intersex): _____ How do you identify your gender? (F, M, or other):_____
Date of Exam _____ Sport(s):_____
Local Phone Number: _____ Email: _____

List past and current medical conditions. _____
_____
Have you ever had surgery? If yes, list all past surgical procedures. _____
_____
Medicine 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

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

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?		
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?		
HEART 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?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	**YES**	**NO**
10. Have you ever had a seizure?		
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)?		
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?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
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?		
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		

MEDICAL QUESTIONS	YES	NO
16. Do you cough, wheeze or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
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?		

MEDICAL QUESTIONS (*CONTINUED*)	YES	NO
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?		
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**YES**	**NO**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

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

Signature of student athlete: _____ Date: _____

Signature of parent/guardian (if athlete is under the age of 18): _____

I have reviewed the questions with the student athlete.

Date: _____

Signature of physician/NP/PA: _____

UC Davis PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Height: _____ Weight: _____ BMI:_____

BP: ____/_____(_____/_____) Pulse: _____ Vision: R20/ _____ L20/ _____ Corrected: Y N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose and throat • Pupils equal • Hearing		
Lymph nodes		
Heart : Murmurs (auscultation standing, auscultation supine, and ± Valvsalva maneuver)		
Lungs		
Abdomen		
Skin: Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Pulses: Simultaneous femoral and radial pulses		
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 box drop or step drop test		

MEDICAL ELIGIBILITY

By signing this Sports Participation Clearance Form, I acknowledge that I have performed a physical examination on this student and have found this student:

☐ Cleared for all sport related activity
☐ Cleared for all sport related activities with the following conditions:
☐ Not Cleared for any sport related activity

Notes:

_____
_____
_____

Patient Label or Clinician's Stamp:

This form is not valid without the patient label or clinician's stamp and will not be accepted.

Name of health care professional: _____ Date: _____

Address:_____ Phone: _____

Signature of health care professional: _____, MD, DO, NP or PA (Circle applicable)