

# TSSAA PREPARTICIPATION EVALUATION

# HISTORY FORM

DATE OF EXAM: \_\_\_\_\_

NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

GRADE: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ SPORT(S): \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

PERSONAL PHYSICIAN: \_\_\_\_\_

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

1. Has a doctor ever denied or restricted your participation in sports for any reason? ..... Y N
2. Do you have an ongoing medical condition (like diabetes or asthma)? ..... Y N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? ..... Y N
4. Do you have allergies to medicines, pollens, foods, or stinging insects? ..... Y N
5. Have you ever passed out or nearly passed out DURING exercise? ..... Y N
6. Have you ever passed out or nearly passed out AFTER exercise? ..... Y N
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? ..... Y N
8. Does your heart race or skip beats during exercise? ..... Y N
9. Has a doctor ever told you that you have:  
High Blood Pressure ..... Y N  
High Cholesterol ..... Y N  
A heart murmur ..... Y N  
A heart infection ..... Y N
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) ..... Y N
11. Has anyone in your family died for no apparent reason? ..... Y N
12. Does anyone in your family have a heart problem? ..... Y N
13. Has any family member or relative died of heart problems or of sudden death before age 50? ..... Y N
14. Does anyone in your family have Marfan Syndrome? ..... Y N
15. Have you ever spent the night in a hospital? ..... Y N
16. Have you ever had surgery? ..... Y N
17. Have you every had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? ..... Y N  
If Yes, explain: \_\_\_\_\_
18. Have you had any broken or fractured bones or dislocated joints? ..... Y N  
If Yes, explain: \_\_\_\_\_
19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? ..... Y N  
If Yes, explain: \_\_\_\_\_
20. Have you ever had a stress fracture? ..... Y N
21. Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability? ..... Y N
22. Do you regularly use a brace or assistive device? ..... Y N

23. Has a doctor ever told you that you have asthma or allergies? ..... Y N
24. Do you cough, wheeze or have difficulty breathing during or after exercise? ..... Y N
25. Is there anyone in your family who has asthma? ..... Y N
26. Have you ever used an inhaler or taken asthma medicine? ..... Y N
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ..... Y N
28. Have you had infectious mononucleosis (mono) within the last month? ..... Y N
29. Do you have rashes, pressure sores, or other skin problems? ..... Y N
30. Have you ever had a herpes skin infection? ..... Y N
31. Have you ever had a head injury or concussion? ..... Y N
32. Have you been hit in the head and been confused or lost your memory? ..... Y N
33. Have you ever had a seizure? ..... Y N
34. Do you have headaches with exercise? ..... Y N
35. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? ..... Y N
36. Have you ever been unable to move your arms or legs after being hit of falling? ..... Y N
37. When exercising in the heat, do you have severe muscle cramps or become ill? ..... Y N
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ..... Y N
39. Have you had any problems with your eyes or vision? ..... Y N
40. Do you wear glasses or contact lenses? ..... Y N
41. Do you wear protective eyewear, such as goggles or a face shield? ..... Y N
42. Are you happy with your weight? ..... Y N
43. Are you trying to gain or lose weight? ..... Y N
44. Has anyone recommended you change your weight or eating habits? ..... Y N
45. Do you limit or carefully control what you eat? ..... Y N
46. Do you have any concerns that you would like to discuss with a doctor? ..... Y N

### FEMALES ONLY

47. Have you ever had a menstrual period? ..... Y N
48. How old were you when you had your first menstrual period? \_\_\_\_\_
49. How many periods have you had in the last 12 Months? \_\_\_\_\_

Explain "Yes" answers here: \_\_\_\_\_

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

Athlete's Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TSSAA PREPARTICIPATION EVALUATION**

**PHYSICAL EXAMINATION FORM**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ % BODY FAT (OPT.): \_\_\_\_\_

PULSE: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

VISION R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ CORRECTED: Y N PUPILS: EQUAL \_\_\_\_\_ UNEQUAL \_\_\_\_\_

**Follow-Up Questions on More Sensitive Issues**

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

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)**			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/Toes			

\*Multiple-examiner set-up only. \*\*Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_  
 \_\_\_\_\_

Name of physician (print/type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of physician: \_\_\_\_\_, MD or DO

NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

GRADE: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

\_\_\_\_\_ 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: \_\_\_\_\_

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; pneumococcal; meningococcal; varicella)

\_\_\_\_\_ Up to date (see attached documentation) \_\_\_\_\_ Not up to date - Specify \_\_\_\_\_

**Name of physician (print/type):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Signature of physician:** \_\_\_\_\_, **MD or DO**

Adapted from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, & American Ortheopathic Academy of Sports Medicine 2004 PPE Form.