



# Ohio High School Athletic Association Preparticipation Physical Evaluation



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

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Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

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

Personal Physician \_\_\_\_\_

**In case of emergency, contact:** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Cell) \_\_\_\_\_

## History

**This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.**

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

- 1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No
- 2. Do you have an ongoing medical condition (like diabetes or asthma)? Yes No
- 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Yes No
- 4. Do you have allergies to medicines, pollens, foods, or stinging insects? Yes No
- 5. Do you think you are in good health? Yes No
- 6. Have you ever passed out or nearly passed out DURING exercise? Yes No
- 7. Have you ever passed out or nearly passed out AFTER exercise? Yes No
- 8. Have you ever had discomfort, pain, or pressure in your chest during exercise? Yes No

- 9. Does your heart race or skip beats during exercise? Yes No
- 10. Has a doctor ever told you that you have (check all that apply):  
 High Blood Pressure  A heart murmur  
 High Cholesterol  A heart infection
- 11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) Yes No
- 12. Has anyone in your family died of no apparent reason? Yes No
- 13. Does anyone in your family have a heart problem? Yes No
- 14. Has any family member or relative died of heart problems or of sudden death before age 50? Yes No
- 15. Does anyone in your family have Marfan syndrome? Yes No
- 16. Have you ever spent the night in a hospital? Yes No
- 17. Have you ever had surgery? Yes No

18. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:

19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:

20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:

|            |            |          |           |       |           |                |             |
|------------|------------|----------|-----------|-------|-----------|----------------|-------------|
| Head       | Neck       | Shoulder | Upper Arm | Elbow | Forearm   | Hand / Fingers | Chest       |
| Upper back | Lower back | Hip      | Thigh     | Knee  | Calf/shin | Ankle          | Foot / Toes |

- 21. Have you ever had a stress fracture? Yes No
- 22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No
- 23. Do you regularly use a brace or assistive device? Yes No
- 24. Has a doctor ever told you that you have asthma or allergies? Yes No

- 25. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No
- 26. Is there anyone in your family who has asthma? Yes No
- 27. Have you ever used an inhaler or taken asthma medicine? Yes No
- 28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Yes No
- 29. Have you had infectious mononucleosis (mono) within the last month? Yes No
- 30. Do you have any rashes, pressure sores, or other skin problems? Yes No
- 31. Have you had a herpes skin infection? Yes No
- 32. Have you ever had a head injury or concussion? Yes No
- 33. Have you been hit in the head and been confused or lost your memory? Yes No
- 34. Have you ever had a seizure? Yes No
- 35. Do you have headaches with exercise? Yes No
- 36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No
- 37. Have you ever been unable to move your arms or legs after being hit or falling? Yes No
- 38. When exercising in the heat, do you have severe muscle cramps or become ill? Yes No
- 39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Yes No
- 40. Have you had any problems with your eyes or vision? Yes No
- 41. Do you wear glasses or contact lenses? Yes No
- 42. Do you wear protective eyewear, such as goggles or a face shield? Yes No
- 43. Are you happy with your weight? Yes No
- 44. Are you trying to gain or lose weight? Yes No
- 45. Has anyone recommended you change your weight or eating habits? Yes No
- 46. Do you limit or carefully control what you eat? Yes No
- 47. Do you have any concerns that you would like to discuss with a doctor? Yes No
- 48. Record the dates of your most recent immunizations (shots)  
Tdap \_\_\_\_\_ MMR \_\_\_\_\_ Hepatitis B \_\_\_\_\_  
Chicken Pox \_\_\_\_\_ Meningococcal \_\_\_\_\_

### FEMALES ONLY

- 49. Have you ever had a menstrual period? Yes No
- 50. How old were you when you had your first menstrual period? \_\_\_\_\_
- 51. How many periods have you had in the last 12 months? \_\_\_\_\_

Explain "Yes" Answers Here: (Attach additional sheets as needed)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Athlete Parent or Guardian (If athlete is under 18)

The student has family insurance  Yes  No; If yes, family insurance company name and policy number: \_\_\_\_\_

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.  
NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION