IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Please complete and sign this form (with your parents if younger than 18) before your appointment.

Name: ______________________________ Date of Birth: ____________________

Date of Examination: ______________________ Sport(s): ____________________

Home Address (Street, City, Zip): __________________ School District: ________________

Parent's/Guardian's Name: ____________________ Phone #: ____________________

Physician: ______________________________ Phone #: ____________________

History Form:

List past and current medical conditions.

____

Have you ever had a 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 (to medicines, pollen, food, stinging insects, etc.)

____

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 Everyday
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)

SCORE: ____

In the section below, if you answer "yes" to any questions, please explain further in the space provided at the end of this form. Circle any questions you don't know the answer to.

General Questions:

Y N

☐ ☐ Do you have any concerns that you would like to discuss with your provider?

☐ ☐ Has a provider ever denied or restricted your participation in sport for any reason?

☐ ☐ Do you have any ongoing medical issues or recent illnesses?

Heart Health Questions:

Y N

☐ ☐ Have you ever passed out of nearly passed out during or after exercise?

☐ ☐ Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?

☐ ☐ Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?

☐ ☐ Has a doctor ever told you that you have any heart problems?

☐ ☐ Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?

☐ ☐ Do you get lightheaded or feel shorter of breath than your friends during exercise?

☐ ☐ Do you have high blood pressure or high cholesterol?

Questions about your Family:

Y N

☐ ☐ 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)?

☐ ☐ 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)?

☐ ☐ Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?

☐ ☐ Does anyone in your family have asthma?

Bone and Joint Questions:

Y N

☐ ☐ 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?

☐ ☐ Have you had an X-ray, MRI, CT scan or physical therapy for any reason?

☐ ☐ Do you have a bone, muscle, ligament or joint injury that bothers you?

☐ ☐ Do you currently, or have you in the past worn orthotics, braces or protective equipment for any reason?

Medical Question:

Y N

☐ ☐ Do you cough, wheeze or have difficulty breathing during or after exercise?

☐ ☐ Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?

☐ ☐ Do you have groin or testicle pain or a painful bulge or hernia in the groin area?

☐ ☐ Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?

☐ ☐ Have you had a concussion? Or a head injury that caused confusion, a prolonged headache, or memory problems?

☐ ☐ Have you ever had a seizure?

☐ ☐ Do you get frequent headaches?

☐ ☐ Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?

☐ ☐ Have you ever become ill when exercising in the heat?

☐ ☐ Do you have sickle cell trait or disease? Or anyone in your family?

☐ ☐ Have you ever had or do you have any problems with your eyes or vision?

☐ ☐ Do you worry about your weight?

☐ ☐ Are you trying to or has anyone recommended that you gain or lose weight?

☐ ☐ Are you on a special diet or do you avoid certain types of foods or food groups?

☐ ☐ Have you ever had an eating disorder?

FEMALES only:

Y N

☐ ☐ 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 last 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 Athlete: ______________________________

Signature of Parent or Guardian: ______________________________ Date: ____________________

Physical Examination *(To be filled out by medical provider)*

Consider additional questions as below:

Y	N	
☐	☐	Do you feed stressed out or under a lot of pressure?
☐	☐	Do you ever feed sad, hopeless, depressed or anxious?
☐	☐	Do you feel safe at your home or residence?
☐	☐	Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?
☐	☐	Do you drink alcohol or use any other drugs?
☐	☐	Have you taken prescriptions medications that were not yours or outside of their intended use?
☐	☐	Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
☐	☐	Have you ever taken any supplements to help you gain or lose weight or improve your performance?
☐	☐	Do you wear a seat belt and a helmet?
☐	☐	Do you use condoms if you are sexually active?

EXAMINATION

Height: ________________ Weight: ________________

BP: _____ / _____ (____/_____) Pulse: ________ Vision: R 20/____ L 20/____ 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 ± Valsalva)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus, lesions suggestive of MRSA or Tinea Corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, hand, and fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional • May include: Duck Walk, Double-leg squat test, single-leg squat test, and box drop or step drop test		

- Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings or a combination of those.

Medical Eligibility Form

Student Athlete Name: ______________________ Date of Birth: ____________ Date of Examination: __________

I acknowledge and give consent for a copy of this entire form to be kept in the student's school record. I agree that should student's health change in any way that would alter this form that I will inform the school as soon as possible.

Signature of Parent or Guardian: ____________________________ Date: ____________________

Shared Emergency Information *(To be filled out by athlete/athlete's caregiver)*

Allergies:

____

Medications:

____

Other Information:

____

Emergency Contacts:

Name	Relationship	Contact Information

Participation Eligibility *(To be filled out by medical provider)*

☐ Medically Eligible for sports without restriction.

☐ Medically Eligible for all sports without restriction with recommendations for further evaluation or treatment of:

____

☐ Medically eligible for certain sports:

____

☐ Not medically eligible pending further evaluation

____

☐ Not medically eligible for any sports

Recommendations:

____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined in this form. A copy of the physical examination findings is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print): ____________________________ Date: ______________

Address: ____________________________________ Phone: ______________

Signature of health care professional:

____