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	Date of Birth:			
Date of Examination:				Sport(s	Sport(s):			
Home Address (Street, City, Zip):					School District:			
Parent's/Guardian's Name:					Phone #:			
Physician:					Phone #:			
Hi	stor	y Form:						
List	past	and current medical conditions.						
Ha	ve yo	u ever had a surgery? If "yes", list all past s	surgical procedur	es.				
Me	dicin	es and Supplements: List all current prescr	riptions, over-the	-counter medicines	and supplements (herba	l and nutritional).		
Do	you h	nave any allergies? If yes, please list all you	ur allergies (to me	edicines, pollen, foo	od, stinging insects, etc.)			
РΗ	Q-4:	Over the last 2 weeks, how often have you	u been bothered l	by any of the follow	ving problems? (Circle Res	sponse)		
			Not at all	Several Days	Over half the days	Nearly Everyday		
-		nervous, anxious, or on edge	0	1	2	3		
_		ing able to stop or control worrying	0	1	2	3		
_		terest or pleasure in doing things	0	1	2	3		
		down, depressed or hopeless	0	1	2	3		
(A	sum	of ≥3 is considered positive on either subsc	ale [Questions 1 o	and 2, or Questions	3 and 4] for screening pu	rposes)		
SCO	ORE:							
		ection below, if you answer "yes" to any c ny questions you don't know the answer t	= =	explain further in	the space provided at the	end of this form.		
Ge	neral	Questions:						
Υ	Ν							
		Do you have any concerns that you would like to discuss with your provider?						
		Has a provider ever denied or restricted y	our participation	in sport for any rea	ason?			
		Do you have any ongoing medical issues of	or recent illnesses	5?				
He	art He	ealth Questions:						
Υ	Ν							
		Have you ever passed out of nearly passe	ed out during or a	fter 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?						

Qu	Questions about your Family:						
Υ	Ν						
		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?					
D		d Leist Overtiere					
		d Joint Questions:					
Y	N	Have you over had a stress fracture or an injury to a hand muscle ligament joint, or tenden that sourced you to miss a					
		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?					
Me Y	dical N	Question:					
		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?					
		Have you ever had an eating disorder?					
		S 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?					
Ш	ш	now many perious have you had in the last 12 months:					
EXF	PLAIN	"Yes" answers here:					
I he	ereby	state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.					
	_						
Sigi	ıatur	re of Athlete:					

Signature of Parent or Guardian:

Date: _____

Physical Examination (To be filled out by medical provider)

	er additional questions as below:						
Y N	Davis facilities and automorphism a late of massacra?						
	Do you feel stressed out or under a lot of pressure?						
	Do you ever feel sad, hopeless, depressed or anxious?						
	Do you feel safe at your home or residence?	-3					
	Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip	or.					
	Do you drink alcohol or use any other drugs?	. (1					
	Have you taken prescriptions medications that were not yours or outside						
	Have you ever taken anabolic steroids or used any other performance-en						
	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?						
EXAMIN	NATION						
Height:	Weight:						
BP:	/ () Pulse: Vision: R 20/	L 20/	Corrected Y / N				
MEDIC	CAL	NORMAL	ABNORMAL FINDINGS				
Appea	rance						
•	Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)						
Eyes, e	ears, nose and throat						
•	Pupils equal & Hearing						
Lymph	Nodes						
Heart							
•	Murmurs (auscultation standing, auscultation supine, and ± Valsalva)						
Lungs							
Abdon	nen						
Skin							
•	Herpes Simplex Virus, lesions suggestive of MRSA or Tinea Corporis						
Neuro							
MUSCULOSKELETAL NORMAL FINDING							
Neck							
Back Control of the C							
	der & 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,							
•							

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

Medical Eligibility Form

Studer	nt Athlete Name:	Date of	Date of Birth:			
		or a copy of this entire form to be uld alter this form that I will inform	=	's school record. I agree that should student's n as possible.		
Signati	ure of Parent or Guardian: _		Date:			
Share	ed Emergency Informat	ion (To be filled out by athlete/d	nthlete's caregiver)			
Allerg						
Medic	cations:					
Other	Information:					
Name	gency Contacts:	<u>Relationship</u>		et Information		
		e filled out by medical provider				
	Medically Eligible for sp	oorts 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:					
appare examinarise a	ent clinical contraindications nation findings is on record i fter the athlete has been cle	to practice and can participate ir in my office and can be made ava	n the sport(s) as out ilable to the school ler may rescind the	chysical evaluation. The athlete does not have clined in this form. A copy of the physical at the request of the parents. If conditions medical eligibility until the problem is resolved or guardians).		
Name	of health care profession	Date:				
Addre	ess:			Phone:		
Signat	cure of health care profess	sional:				