



PREPARTICIPATION PHYSICAL EVALUATION | Ohio High School Athletic Association – 2021-2022

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____ Grade in School: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions: _____

Have you ever had 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 (i.e., 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.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		
	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
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?		

COVID-19 QUESTIONS ABOUT YOU	Yes	No
14. Have you had COVID-19 or tested positive for COVID-19?		
15. If answered yes, when did you have/test positive for COVID-19?		
16. If answered yes, have you had any ongoing medical issues secondary to COVID-19?		
17. If answered yes, were you cleared by a health care provider following the diagnosis to return to sport activity?		
18. Has a physician ever denied or restricted your participation in sports for reasons related to COVID-19?		
19. If answered yes, please state reasoning:		
20. Have you been vaccinated for COVID-19?		
21. Please list date(s) of vaccine(s), if applicable:		
BONE & JOINT QUESTIONS	Yes	No
22. 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?		
23. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
27. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
28. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
29. 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?		
30. Have you ever become ill while exercising in the heat?		
31. Do you or does someone in your family have sickle cell trait or disease?		
32. Have you ever had, or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
33. Do you worry about your weight?		
34. Are you trying to or has anyone recommended that you gain or lose weight?		
35. Are you on a special diet or do you avoid certain types of foods or food groups?		
36. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
37. Have you ever had a menstrual period?		
38. How old were you when you had your first menstrual period?		
39. When was your most recent menstrual period?		
40. How many periods have you had in the past 12 months?		

Explain "Yes" answers here:

Additional questions, as authorized by the Ohio High School Athletic Association, were not a part of the revised 5th edition PPE as authored by the American Academy of Pediatrics and are optional.

1. On average, how many days per week do you engage in moderate to strenuous exercise (makes you breathe heavily or sweat)? _____
2. On average, how many minutes per week do you engage in exercise at this level? _____

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: _____

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ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here:

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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: _____