MINION PHYSICAL EVALUATION

HISTORY FORM

Name:		
Sex Age		School
List past and current medical conditions		
Have you ever had surgery? If yes, list all pa	ast surgical procedures.	
Medicines and supplements: List all current	prescriptions, over-the-	counter medicines, and supplements (herbal and nutritional).
		(r. r. r. r. r. r. 1)
Do you have any allergies? If yes, please list a	all your allergies (ie, med	licines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHO	2-4)			
Over the last 2 weeks, how often have you be	en bothered by an	y of the following	ng problems? (Circle re	esponse.)
	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 \geq 3 is considered positive on either	subscale [question	ns 1 and 2, or qu	uestions 3 and 4] for so	creening purposes.)

(Ex	NERAL QUESTIONS plain "Yes" answers at the end of this form. cle questions if you don't know the answer.) Do you have any concerns that you would like to discuss with your provider?	Yes	No
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?	- 13	* #* -
GE	ART HEALTH QUESTIONS ABOUT YOU	Yes	100
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.		

of the supplement	RT: HEALTH QUESTIONS ABOUT YOU NTINUED)	Yes	No
9.	Do you get light-headed or feel shorter of breath than your friends during exercise?	5,4) e :==
10.	Have you ever had a seizure?		
HEA	RT 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 poly- morphic ventricular tachycardia (CPVT)?		
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

			Tarana and and	nteres are said		SHEET HARD SALE	Translation and
BONE A	IND JOINT QUESTIONS	Yes	No	MEDI	CAL QUESTIONS (CONTINUED)	Yes	No
14.	Have you ever had a stress fracture or an			25.	Do you worry about your weight?		
	injury to a bone, muscle, ligament, joint, or			26.	Are you trying to or has anyone		
	tendon that caused you to miss a practice or game?				recommended		
15	Do you have a bone, muscle, ligament, or	-			that you gain or lose weight?		
15.	joint injury that bothers you?		-	27.	Are you on a special diet or do you avoid		
	QUESTIONS		No.		certain types of foods or food groups?		
		100	見という		Have you ever had an eating disorder?	THE PROPERTY OF	HOUSE
16.	Do you cough, wheeze, or have difficulty		74	PEDVIAG	es only.	Yes	No
	breathing during or after exercise?	-		29.	Have you ever had a menstrual period?	4	
7.	Are you missing a kidney, an eye, a			30.	How old were you when you had your first	=	
	testicle (males), your spleen, or any other organ?				menstrual period?		
8	Do you have groin or testicle pain or a			31.	When was your most recent menstrual period?		
	painful bulge or hernia in the groin area?		4,	32.	How many periods have you had in the past 12		
9	Do you have any recurring skin rashes or	-		1	months?		
•	rashes that come and go, including herpes						
	or methicillin-resistant Staphylococcus			Explain	"Yes" answers here.		
	aureus (MRSA)?						
0.	Have you had a concussion or head injury			l —			
	that caused confusion, a prolonged			-			
	headache, or memory problems?						
1.	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?						
22.	Have you ever become ill while exercising in						
ß	the heat?						-
23.	Do you or does someone in your family						
	have sickle cell trait or disease?			-			
24.	Have you ever had, or do you have any						
	problems with your eyes or vision?						
				- 5			
ohu	state that to the best of my knowledge	70 MY	ancura	ers to the a	uestions on this form are complete and c	orrect	
					descions on this form are complete and t	OI I COL	
atur	e of athlete:						
atur	e of parent or guardian:						
iatui	c or parent or guardian.)		

■ NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.		
Name: Date of Birth		
1. Date of disability:		
2. Classification (if available):		
3. Cause of disability (birth, disease, injury or other):		
4. 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?	22	
9. Do you have a hearing loss? Do you use a hearing aid?	-	100
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?		7.1
15. Do you have muscle spasticity?		- 7
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		r 1
Dislocated joints (more than one)		
Easy bleeding	3 F 3:	7 H
Enlarged spleen	<u> </u>	. The
Hepatitis	-	- 75
Osteopenia or osteoporosis		
Difficulty controlling bowel	\perp	_
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	1	
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		
explain "Yes" answers here.		
hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and o	orrect	
ignature of athlete:		
ignature of parent or guardian: Date:		

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M NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM Date of birth: Name: PHYSICIAN REMINDERS 1. Consider additional questions on more-sensitive issues. · 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? · Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip? · During the past 30 days, did you use chewing tobacco, snuff, or dip? · Do you drink alcohol or use any other drugs? 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, use a helmet, and use condoms? 2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History EXAMINATION Height: Vision: R 20/ L 20/ 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^a • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) Lungs Abdomen Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or Neurological MUSCULOSKELETAL NORMAL ABNORMAL FINDINGS Back Shoulder and arm Elbow and forearm Wrist, hand, and fingers Hip and thigh Knee Leg and ankle Foot and toes **Functional** 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. Name of health care professional (print or type):______ Date: Phone:

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Signature of health care professional:

____, MD, DO, NP, or PA

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Name	DICAL ELIGIBILITY FORM e:	Date of birth:	
	Medically eligible for all sports without restricti	on	
	Medically eligible for all sports without restricti	on with recommendations for further evaluation or treatment of	
	Medically eligible for certain sports		
_	Not medically eligible pending further evaluatio	n	
	Not medically eligible for any sports		
Ro	Recommendations:		
co m th	contraindications to practice and can participate in the sp ny office and can be made available to the school at the	npleted the preparticipation physical evaluation. The athlete does not have appar port(s) as outlined on this form. A copy of the physical examination findings are or request of the parents. If conditions arise after the athlete has been cleared for problem is resolved and the potential consequences are completely explained to	record in articipation
Name	of health care professional (print or type)	Date	
		Date:Phone:	
Addres Signatu SHARED	ess:ture of health care professional: D EMERGENCY INFORMATION	Date:Phone:, MD, DO	, NP, or P
Addres Signatu SHARED Allergies	ess: ture of health care professional: D EMERGENCY INFORMATION es: tions:	Phone:, MD, DO	, NP, or P
Addres Signatu SHARED Allergies Medicati	ess: ture of health care professional: D EMERGENCY INFORMATION es: tions:	Phone:, MD, DO	, NP, or P
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Address Signatu SHARED Allergies Medicati Other Inf Emergen PERMISS In the every lill be m	ture of health care professional: DEMERGENCY INFORMATION es: tions: nformation: ncy Contacts: SION FOR MEDICAL TREATMENT event of an emergency requiring medical attention, I here	Phone:, MD, DO, MD, DO, by grant permission for emergency treatment for my daughter/son. I expect an ed the cost for any medical attention may not be covered or paid by any high school	, NP, or P
Address Signatu SHARED Allergies Wedicati Other Inf Emergen PERMISS In the every lill be mine North	ture of health care professional: D EMERGENCY INFORMATION es: tions: nformation: ncy Contacts: SION FOR MEDICAL TREATMENT event of an emergency requiring medical attention, I here made to contact me if an emergency occurs. I understand th Dakota High School Activities Association. I hereby ap	Phone:, MD, DO, MD, DO, by grant permission for emergency treatment for my daughter/son. I expect an ed the cost for any medical attention may not be covered or paid by any high school	, NP, or P