CRESPI CARMELITE HIGH SCHOOL PRE- PARTICIPATION PHYSICAL

Student First & Last Name_____ Date of birth_____

Sport/Classes/Activities Participating in _____Grade_____

*(Pages 1-2 should be **completed by students** and **parent/guardian** prior to the physical exam)*

HISTORY FORM

Primary Physician Name:	**Physician Address:**

List past & current medical conditions [Identify Month & Year]

Has student had surgeries? If yes, list all procedures [Identify Month & Year]

ALLERGIES: Do you have any allergies ☐NO ☐YES, please explain the specific allergies below:
☐Medicines: _____ ☐Pollens: _____ ☐Foods: _____ ☐Stinging Insects_____

MEDICINES: Please list all prescribed and over- the- counter medicines and supplements (herbal and nutritional) currently student is taking:

Patient Health Questionnaire Version 4 (PHQ-4)
Over the last 2 weeks, how often have you been bothered by any of the following problems?

	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 control worrying	0 ☐	1 ☐	2☐	3 ☐
Little interest or pleasure in doing things	0 ☐	1 ☐	2☐	3 ☐
Feeling down	0 ☐	1 ☐	2☐	3 ☐

A sum of ≥ 3 is considered positive on either subscale [question 1 and 2, or question 3 and 4] for screening purposes

General Questions	YES	NO
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have an ongoing medical issues or recent illness?	☐	☐

Please further explain the above "YES" answers. Please include month & year

Cardiac and Pulmonary Health Questions	YES	NO
4. Have you ever passed out or nearly padded out during or after exercise?	☐	☐
5. Do you get light-headed or feel excessive shortness of breath with exercise?	☐	☐
6. Have you had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
7. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐	☐
8. Has a doctor ever told you that you have any heart problems?	☐	☐
9. Has a doctor ever requested a test for your heart ie. Electrocardiography (ECG/EKG) or Echo?	☐	☐
10. Have you ever been told you have a heart murmur?	☐	☐
11. Has your doctor ever told you that you have any heart problems that have not been mentioned already?	☐	☐
12. Do you drink energy Drinks? If yes, how many per day _____	☐	☐
13. Have you previously had or currently have high blood pressure?	☐	☐
14. Has the doctor ever told you have high cholesterol?	☐	☐

Please further explain the above "YES" answers. Please include month & year

Family History Heart Health	YES	NO
15. Has any family member in your family member or relative died of heart problems or had unexpected or unexplained sudden death before age of 35 years (including drowning or unexplained car crash)?	☐	☐
16. 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] Bragada syndrome, or catecholaminergic polymorphic ventricular tachycardia [CPVT] *explain below which one.*	☐	☐
17. Has anyone in your family had a pacemaker or implanted defibrillator before age 35	☐	☐

Please further explain the above "YES" answers. Please include month & year

Musculoskeletal – Bone and Joint Questions	YES	NO
18. Have you ever had a stress fracture or any injury to a bone, muscle, ligament, joint, or tendon that caused you to miss practice/games?	☐	☐
19. Do you currently have a bone, muscle, ligament, or joint injury that bothers you?	☐	☐
20. Do you experience or previous experienced muscle cramps	☐	☐

21. Are you currently using any supportive braces or have orthotics?	☐	☐

Please further explain the above "YES" answers. Please include month & year

Medical Questions	YES	NO
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
23. Have you ever tested positive for COVID? Last positive test: _____ Symptoms associated with diagnosis: _____	☐	☐
24. Are you missing a kidney, an eye, a testicle, spleen, or any other organ?	☐	☐
25. Do currently or previously sustained groin or testicle pain or a painful bulge or hernia in the groin area	☐	☐
26. Have you previously or currently had any recurring skin rashes or have has, including herpes or methicillin-resistant *Staphylococcus aureus (MRSA). Tinea Corporis*	☐	☐
27. Have you ever been diagnosed with seizures?		
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?	☐	☐
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 group?	☐	☐
36. Have you ever had an eating disorder?	☐	☐
37. Have you been diagnosed diabetic?	☐	☐

Please further explain the above "YES" answers. Please include month & year

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are completed correctly at the time in which the physical was completed.

STUDENT PRINT	**PARENT/GUARDIAN PRINT**
STUDENT SIGNATURE	**PARENT SIGNATURE**
DATE:	DATE:

I am giving Crespi Sports Medicine permission to communicate with health care provider

☐ YES, able to contact health care provider.

☐NO, unable to communicate with healthcare provider.

PARENT/GARDIAN SIGNATURE

Please be sure pages 1-2 are reviewed and saved in patience medical file with the facility

CRESPI CARMELITE

CRESPI CARMELITE HIGH SCHOOL PRE- PARTICIPATION PHYSICAL

PHYSICAN USE ONLY
PHYSICAL EVALUATION

Student Name:	**Date of Birth:**

EXAMINATION			
HEIGHT:	**WEIGHT:**	**BP:** / (/)	**Pulse:**
Vision: R 20/ L 20/	**Corrected:** ☐ Y ☐ N ☐Contacts ☐Glasses ☐ Both	If Corrected explain use: ☐ Reading Only ☐ Sports ☐ Used for both ☐ Other_____	

MEDICAL	NORMAL	ABNORMAL FINDINGS/NOTES
Appearance ▪ Marfan stigmata (kyphoscoliosis, high – arches palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapses [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat ▪ Pupils Equal & Hearing		
Lymph Nodes		
Heart ▪ Murmurs (auscultations standing, auscultation supine, and ± Valsalva maneuver)	☐ NO ECG/EKG/ECHO ☐ Not Necessary	*Consider* ☐ ECG/EKG ☐ ECHO
Lungs		
Abdomen		
Skin Herpes simplex (HSV), lesions suggestive of methicillin-resistance *Staphylococcus* aureus (MRSA), or Tinea Corporis, Eczema, Psoriasis		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS/NOTES
Neck		
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

☐ **Cleared with NO restrictions**

☐ **Medically eligible with recommendations for further evaluation or treatment:** _____

_____

_____

☐ **Medically eligible for certain sports.**

_____

☐ **NOT** medically eligible_____

☐ **NOT** medical eligible for any sports

Recommendations

_____

_____

_____

By signing below, physician has reviewed pages 1-2 and has verified that the parents have consented that the physician office may contact me (physician) regarding this student

☐YES ☐NO

Physician Signature

Physician Stamp Below

Name of Physician (Print) MD/DO/NP/PA	**Date of Exam**
Physician Signature MD/DO/NP/PA	