This form should be placed into the athlete's medical file and should **not** be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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Note: Complete and sign this form (with your pare Name:			pointment. te of birth:	
Date of examination:				
Sex assigned at birth (F, M, or intersex):	How do you identif	y your gender? (F, I	M, non-binary, or anoth	ner gender):
Have you had COVID-19? (check one): □ Y □	□ N			
Have you been immunized for COVID-19? (check	k one): □Y □N		u had: □ One shot [□ Booster date(s)	
List past and current medical conditions.				
Have you ever had surgery? If yes, list all past surg				
Medicines and supplements: List all current prescr	riptions, over-the-co	unter medicines, a	nd supplements (herba	and nutritional).
Do you have any allergies? If yes, please list all y	our allergies (ie, me	dicines, pollens, fo	ood, 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 prob	lems? (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 eithe	er subscale [question	s 1 and 2, or ques	tions 3 and 4] for scree	ening purposes.)

(Ехр	IERAL QUESTIONS lain "Yes" answers at the end of this form. Circle stions 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?		
HEA	RT 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.		

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	ART HEALTH QUESTIONS ABOUT YOU ONTINUED)		Yes	No
9.	Do you get light-headed or feel shorter of breathan your friends during exercise?	ith		
10.	Have you ever had a seizure?			
HEA	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	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?			

O	NE AND JOINT QUESTIONS	Yes	No	MEDIC	CAL QUESTIONS (CONTINUED)	
4.	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?			26. A	Do you worry about your weight? Are you trying to or has anyone recommend you gain or lose weight?	ded that
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. A	Are you on a special diet or do you avoid c ypes of foods or food groups?	ertain
MEI	DICAL QUESTIONS	Yes	No	28. F	lave you ever had an eating disorder?	
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?				TRUAL QUESTIONS tave you ever had a menstrual period?	N/A
17.	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?			30. F	How old were you when you had your first to period?	menstrual
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?				When was your most recent menstrual perion How many periods have you had in the pas	
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			m	n "Yes" answers here.	
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?					
21.	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 the heat?					
23.	Do you or does someone in your family have sickle cell trait or disease?					
	Have you ever had or do you have any problems					

Yes No

Yes No

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Signature of athlete: __

Date: _____

Signature of parent or guardian: