UTICA PARK CLINIC: PPE H&P

Attachment A

HISTORY Date of examination _____

Name _____ Sex M/F Age ___ DOB _____
Activities(s) _____ Year 1 2 3 4 5

Social Security Number _____

Circle questions to which you don't know the answer. Explain "Yes" answers below.	**Yes**	**No**
1. Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Have you taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Have you had a severe viral infection (for example, *myocarditis* or *mononucleosis*) within the past month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
Have you ever had a stinger, burner or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotic, retainer on your teeth or hearing aid)?	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
12. Have you ever had a sprain, strain or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, check appropriate box and explain below.

☐ Head ☐ Elbow ☐ Thigh ☐ Neck ☐ Forearm ☐ Knee ☐ Back ☐ Wrist ☐ Hip
☐ Shin/calf ☐ Chest ☐ Hand ☐ Ankle ☐ Shoulder ☐ Finger ☐ Foot ☐ Upper arm

13. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14. Do you feel stressed out?	☐	☐

15. What are the dates of your most recent immunizations (shots) for:
Tetanus? _____ Measles? _____ Hepatitis B? _____ Chickenpox? _____

Females Only

16. When was your first menstrual period? _____ When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the past year? _____

Explain "Yes" answers here:

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ **Signature of parent/guardian** _____ **Date** _____

Utica Park Clinic Pre-participation History & Physical Evaluation

PHYSICAL EXAMINATION

Name _____ DOB _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils Equal_____ Unequal_____

	Normal	Abnormal findings
MEDICAL		
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

*Station-based examination only

CLEARANCE

☐ Cleared ☐ Cleared after completing evaluation/rehabilitation for

_____

_____

_____

☐ Not cleared for: _____ Reason: _____

Recommendations:

_____

_____

_____

Name of physician _____ Date _____
(Print or type)

Address _____ Phone _____

Signature of physician _____ M.D./D.O.