## Tantasqua Regional High School

## Free Sports Physical Form

Instructions: Please complete, sign, and bring with you to your visit. Thank you.

## ■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance) HISTORY FORM

Name:		ounger than 18) before your appointment Date of birth:			
Date of examination:					
sex assigned at birth (F, M, or intersex):	How do	you identify your	gender? (F, M, or other	):	
Have you had COVID-19? (check one): □ Y □	N				
Have you been immunized for COVID-19? (check	cone): □Y □N		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	iptions, over-the-co	unter medicines, a	nd supplements (herbal	and nutritional).	
Do you have any allergies? If yes, please list all yo	our allergies (ie, me		1	and a substitute of the substi	
		dicines, pollens, to	ood, stinging insects).		
Patient Health Questionnaire Version 4 (PHQ-4)  Over the last 2 weeks, how often have you been been been been been been been bee				1	
Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been been been been been been been bee	bothered by any of	the following prob	lems? (Circle response.		
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Ехр	IERAL QUESTIONS Ilain "Yes" answers at the end of this form. le 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?		
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.		

	RT HEALTH QUESTIONS ABOUT YOU NTINUED)	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?		
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 polymorphic ventricular tachycardia (CPVT)?		
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BON	IE AND JOINT QUESTIONS	Yes	No
14.	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?	77-210	J. An
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?	N.S.	
MED	ICAL QUESTIONS	Yes	No
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	10 00	141/20
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	es <sup>4</sup> le	ķ.
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
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?	E-1	e di sa
23.	Do you or does someone in your family have sickle cell trait or disease?	ree Ro	
24.	Have you ever had or do you have any prob- lems with your eyes or vision?		

	DICAL QUESTIONS (CONTINUED)	Yes	N
25.	Do you worry about your weight?	24.1	
26.	Are you trying to or has anyone recommended that you gain or lose weight?		
27.	Are you on a special diet or do you avoid certain types of foods or food groups?		BIV
28.	Have you ever had an eating disorder?		
FEM	ALES ONLY	Yes	N
29.	Have you ever had a menstrual period?	deller	
30.	How old were you when you had your first menstrual period?	e de	dvi
21	When was your most recent menstrual period?		
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32.	How many periods have you had in the past 12 months?		
32.	How many periods have you had in the past 12 months?	s resi	
32.	How many periods have you had in the past 12 months?	A CONTRACTOR OF THE CONTRACTOR	2 (4)

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:	to the Electrical property of the distribution of the control of the

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