ATHLETIC PRE-PARTICIPATION HEALTH ASSESSMENT

*ADOLESCENT WELL CARE EXAM (Provider Please See Assessment Section on Next Page)

This form is not required as long as the conditions of 18.13.0 are met.

Name: ___________________________________

Birth Date: ______________

Exam Date: _______________

Address: ____ **City:** ________________________ **Zip:**__________________

Phone: __________________________

Sport: _____________________________

HISTORY

PLEASE USE A PEN TO COMPLETE THE FOLLOWING INFORMATION

Note: If the athlete requires medication at school, a game, or practice, the MEDICATION AT SCHOOL form (included in athlete packet) must be signed by the parent and provider for the current school year and returned to the school along with the front copy of this form).

#	Yes	No	Question
1 a.	☐	☐	Have you had any illness/injury recently, or do you have an illness/injury now?
b.	☐	☐	Have you had a medical problem, illness or injury since your last exam?
c.	☐	☐	Do you have any chronic or recurrent illness?
d.	☐	☐	Have you ever had any illness lasting more than a week?
e.	☐	☐	Have you ever been hospitalized overnight?
f.	☐	☐	Have you had any surgery other than tonsillectomy?
g.	☐	☐	Have you ever had any injuries requiring treatment by a physician?
h.	☐	☐	Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
2.	☐	☐	Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)?
3.	☐	☐	Do you have ANY allergies (medicines, bees, foods, or other factors)?
4 a.	☐	☐	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
b.	☐	☐	Do you tire more easily or quickly than your friends during exercise?
c.	☐	☐	Have you ever had any problem with your blood pressure or your heart?
d.	☐	☐	Have any close relatives had heart problems, heart attack or sudden death before they were age 50?
5.	☐	☐	Do you have any skin problems (acne, itching, rashes, etc.)?
6 a.	☐	☐	Have you ever had fainting, convulsions, seizures or severe dizziness?
b.	☐	☐	Do you have frequent severe headaches?
c.	☐	☐	Have you ever had a “stinger” or “burner” or “pinched nerve”?
d.	☐	☐	Have you ever been “knocked out” or “passed out”?
e.	☐	☐	Have you ever had a neck or head injury?
7.	☐	☐	Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
8.	☐	☐	Have you had asthma, or trouble breathing, or cough during or after exercise?
9 a.	☐	☐	Do you wear eyeglasses, contact lenses or protective eye wear?
b.	☐	☐	Have you had any problem with your eyes or vision?
10.	☐	☐	Do you wear any dental appliance such as braces, bridge, plate, retainer?
11 a.	☐	☐	Have you ever had a knee injury?
b.	☐	☐	Have you ever had an ankle injury?
c.	☐	☐	Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
d.	☐	☐	Have you ever had a broken bone (fracture)?
e.	☐	☐	Have you ever had a cast, splint, or had to use crutches?
f.	☐	☐	Must you use special equipment for competition (pads, braces, neck roll, etc.)?
12.	☐	☐	Has it been more than 5 years since your last tetanus booster shot?
13.	☐	☐	Are you worried about your weight?
14.	☐	☐	FEMALES: Have you any menstrual problems?
15.	☐	☐	Have you any medical concerns about participating in your sport?

******* ATHLETE SHOULD NOT WRITE BELOW THIS LINE *******

EXAMINER’S COMMENTS ON ALL “YES” ANSWERS (refer to question number):

____

____

____

White - Athlete Canary - Patient’s Chart

EXAMINATION AND MANDATORY SCREENINGS

Age:____________ Pulse:____________ Height:____________ Weight*:____________ Blood Pressure:____________

*** IF WRESTLING: The Lowest Acceptable Recommended Weight (High School Athletes Only)**

Hearing

MHZ	RIGHT	LEFT
4000	__________	__________
2000	__________	__________
1000	__________	__________
500	__________	__________

Optional

Urinalysis:

Body Fat %:

HCT:

EST VO2 Max:

Vision 20/_______ 20/________

	N	A	Describe abnormal findings:
Development	☐	☐	____
Behavior	☐	☐	____
Social Emotional	☐	☐	____
Mental Health	☐	☐	____

Health Education (Check at least one box) ☐ Nutrition/Weight Control ☐ Adequate Sleep ☐ Smoking ☐ Injury Prevention/Safety

Physical

General appearance (N = Normal A = Abnormal)

	N	A		N	A		N	A
Skin	☐	☐	Head	☐	☐	Ears	☐	☐
Nose	☐	☐	Oropharnyx/Teeth	☐	☐	Neck	☐	☐
Nodes	☐	☐	Chest	☐	☐	Lungs	☐	☐
Heart	☐	☐	Abdomen	☐	☐	Genitalia	☐	☐
Spine	☐	☐	Extremities	☐	☐	Gait	☐	☐
Neurological	☐	☐						

Describe abnormal findings:

____

____

ASSESSMENT

☐ Full participation ☐ Limited participation (describe limitations, restrictions):

____

☐ Participation contraindicated (list reasons):

____

Recommendations (equipment, taping, rehabilitation, etc.):

____

Medications/Dosages (Note: If the athlete requires medication at school, a game, or practice, the MEDICATION AT SCHOOL form (included in athlete packet) must be signed by the parent and provider for the current school year and returned to the school along with the front copy of this form).

*** PROVIDERS MAY BE ABLE TO BILL THIS SPORTS PHYSICAL AS AN ADOLESCENT WELL CARE EXAM IF ALL ELEMENTS ON THIS FORM ARE COMPLETE. IN ADDITION, THIS MAY INCREASE YOUR HEDIS® QUALITY RATING FOR THIS MEASURE.**

DATE: _________________________ **EXAMINER'S SIGNATURE:** ____________________________

EXAMINER'S PHONE: (   )___________________ **PRINT EXAMINER'S NAME:** ___________________________

White - Athlete Canary - Patient's Chart