NWI Eagles FC

PREPARTICIPATION PHYSICAL HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your physician appointment. *History Form is retained by physician/healthcare provider.*

Name: _____ Date of birth: _____

Date of examination: _____

Sex assigned at birth (F, M, or intersex): _____

Current age: _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions.

Have you ever had surgery? _____ If yes, list all past surgical procedures.

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

Do you have any allergies? If yes, please list all your allergies (i.e., Medicines, pollens, food, stinging insects).

_____

Are your required vaccinations current? _____

Patient Health Questionnaire Version 4 (PHQ-4)

Overall, during the last 2 weeks, how often have you been bothered by any of the following problems? (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 either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS

(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)

1. Do you have any concerns that you would like to discuss with your provider? Yes No

2. Has a provider ever denied or restricted your participation in sports for any reason?

   Yes No

3. Do you have any ongoing medical issues or recent illness? Yes No

HEART HEALTH QUESTIONS ABOUT YOU

4. Have you ever passed out or nearly passed out during or after exercise? Yes No

5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?

   Yes No

6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?

   Yes No

7. Has a doctor ever told you that you have any heart problems? Yes No

8. Has a doctor ever requested a test for your heart? Yes No

   (For example, electrocardiography (ECG) or echocardiography.)

9. Do you get light-headed or feel shorter of breath than your friends during exercise?

   Yes No

10. Have you ever had a seizure? Yes No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

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)?

   Yes No

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 poly-morphic ventricular tachycardia (CPVT)?

   Yes No

13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?

Yes No

BONE AND JOINT QUESTIONS

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?

Yes No

15. Do you have a bone, muscle, ligament, or joint injury that bothers you? Yes No

MEDICAL QUESTIONS

16. Do you cough, wheeze, or have difficulty breathing during or after exercise?

Yes No

17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?

Yes No

18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?

Yes No

19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?

Yes No

20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?

Yes No

21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable tomove your arms or legs after being hit or falling?

Yes No

22. Have you ever become ill while exercising in the heat? Yes No

23. Do you or does someone in your family have sickle cell trait or disease? Yes No

24. Have you ever had or do you have any problems with your eyes or vision? Yes No

MEDICAL QUESTIONS (CONTINUED)

25. Do you worry about your weight? Yes No

26. Are you trying to or has anyone recommended that you gain or lose weight? Yes No

27. Are you on a special diet or do you avoid certain types of food and food groups? Yes No

28. Have you ever had an eating disorder? Yes No

FEMALES ONLY

29. Have you ever had a menstrual period? Yes No

30. How old were you when you had your first menstrual period? Yes No

31. When was your most recent menstrual period? _____

32. How many periods have you had in the past 12 months? _____

Explain "Yes" answers here.

_____

_____

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: _____