Preparticipation Physical Evaluation

The Preparticipation Physical Evaluation (PPE) is comprised of the medical history form, a physical examination, and clearance to Participate by a physician. Each year, this paperwork must be on file at BAMS prior to the athletes' participation in BAMS athletics.

Name _____Age _____Sex _____ Date of Birth ___/___/___ Grade _____

Sport(s) _____

Medical History

The gathering of medical history is used to screen for conditions that would place the athlete at unacceptable risk, understanding that it is not possible to achieve a zero-risk circumstance in competitive sports. The medical history shoul be COMPLETED BY THE PARTICIPANTS WITH THEIR PARENTS OR GUARDIANS, and BEFORE THE PHYSICAL EXAM.

Explain "Yes" answers below
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over the counter) medicine or pills?	☐	☐
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has your doctor ever told you that you have (check all that apply) ☐High blood pressure ☐A heart murmur ☐High cholesterol ☐A heart infection		
10. Has your doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
11. Has any one in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or Ligament tear, or tendonitis, that caused you to miss a practice or game? If yes , circle the affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes , circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, OT, surgery, injections, rehabilitation, physical Therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercize?	☐	☐
35. Have you ever had numbness, tingling, or weariness In your arms after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or A face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had your menstrual period?	☐	☐

48. How old were you when you had your first menstrual period? _____

49. how many periods have you had in the last 12 months? _____

Explain "Yes" answers here: _____

_____

_____

_____

_____

_____

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

_____ ____/___/___ _____ ___/___/___

(Student Signature) (Date) (Parent/Guardian Signature) (Date)