EXHIBIT 3
PRE-PARTICIPATION PHYSICAL EVALUATION
(This form is 2 pages and must be submitted via the High Performance Athlete Data Base (Ex3))

History Form - To be completed by athlete prior to physical evaluation

Preparticipation Physical Evalution **HISTORY FORM**

Member Name : **Member # :**
Gender : **Date of Birth :**

Select Season :
PPE Date:
PPE Physician Last Name PPE Physician First Name
Email

Answer each of the following questions with Yes or No. Explain "Yes" answers in the space provided at the end. SAVE when finished.

		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) medicines 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.	Check all that apply (Has your doctor ever told you that you have):		
	☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, Echocardiogram)		
11.	Has anyone 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 tendinitis, that caused you to miss a practice or game? If yes, check affected area below:		
18.	Have you had any broken or fractured bones, or dislocated joints? If yes, check affected area below:		
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, check affected area below:		
	☐ Head ☐ Neck ☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Fore arm ☐ Hand/ fingers ☐ Chest ☐ Upper back ☐ Lower back ☐ Hip ☐ Thigh ☐ Knee ☐ Calf/ shin ☐ Ankle ☐ Foot/ toes		
20.	Have you every 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 or 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 ever had a head injury or concussion?		
32.	Have you ever been hit in the head and been confused or lost your memory?		
33.	Have you ever had a seizure?		
34.	Do you have headaches when exercising?		
35.	Have you ever had numbness, tingling, or weakness in your arms or legs 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 glasses or 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 a 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:

PPE Date :

Height : in Weight : lbs BP : / mmHg

Pulse : bpm Vision R 20/ : Vision L 20/ : Corrected : Pupils :

Follow-up Questions on More Sensitive Issues	Yes	No
1. Do you feel stressed or under a lot of pressure?	○	○
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	○	○
3. Do you feel safe?	○	○
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	○	○
5. During the past 30 days, did you use chewing tobacco, snuff or dip?	○	○
6. During the past 30 days, have you had at least 1 drink of alcohol?	○	○
7. Have you ever taken steroid pills or shots without a doctor's prescription?	○	○
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	○	○

Notes :

	NORMAL	ABNORMAL	Comments (required for abnormal evaluation)
MEDICAL			
Appearance	○	○	
Eyes/ears/nose/throat	○	○	
Hearing	○	○	
Lymph nodes	○	○	
Heart	○	○	
Murmurs	○	○	
Pulses	○	○	
Lungs	○	○	
Abdomen	○	○	
Genitourinary(males only)+	○	○	
Skin	○	○	
MUSCULOSKELETAL			
Neck	○	○	
Back	○	○	
Shoulder/arm	○	○	
Elbow/forearm	○	○	
Wrist/hand/fingers	○	○	
Hip/thigh	○	○	
Knee	○	○	
Leg/ankle	○	○	
Foot/toes	○	○	

+ Having a third party present is recommended for the genitourinary examination.

Notes :

CLEARANCE SECTION

○ Cleared without restriction

○ Cleared,with recommendations for further evaluation or treatment for:

○ Not cleared for ○ All sports ○ Certain sports : Reason :

PHYSICIAN INFORMATION

Last Name: **First Name:**

Phone : **License # :** **Email :**

Address : City :

State : Zip : Date :