LAS VEGAS ELITE RUNNERS

Pre-Participation Physical Evaluation

MEDICAL HISTORY FORM *(Check one)* ◯**Track and Field** ◯**Cross Country**

(Note: This form is to be filled out by the athlete and parent prior to seeing the physician. Please include with Physical Examination Form.)

Athlete Name:_____Sex: ◯ M ◯ F Age:_____ Date of Birth:_____

Medicines: Please list all prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

_____

Allergies: Do you have any allergies? □ Yes □ No Check all that apply: □ Medicines □ Pollens □ Food □ Stinging Insects
If yes, please identify:_____

Do you have a medical alert bracelet or necklace? □ Yes □ No □ Non-Applicable

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any medical conditions: If so, please identify □ Asthma □ Anemia □ Diabetes □ Infections □ Other ___		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		
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, tightness, or pressure in your chest during exercise?		
8. Does your heart race or skip beats (irregular beats) during exercise?		
9. Has your doctor ever told you that you have any heart problems? If so, check all that apply □ High blood pressure □ Heart murmur □ Kawasaki Disease □ High cholesterol □ Heart infection □ Other _____		
10. Has a doctor ever ordered a test for your heart? (ECG/EKG, echocardiogram)		
11. Do you get lightheaded or feel more shortness of breath than expected during exercise?		
12. Have you ever had an unexplained seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
16. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
BONE AND JOINT QUESTIONS		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practices, meets, or games? Ex. Sprain, muscle or ligament tear, tendonitis		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or Atlantoaxial instability?		
22. Do you regularly use a brace, orthotic, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever had an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Where you born without or are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis(mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a Herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of a seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or anyone in your family have sickle cell trait or disease?		
43.Have you had problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear eyeglasses or contact lenses?		
46. Do you wear protective eyewear such as goggles or a face shield?		
47. Are you on a special diet or do you avoid certain types of food?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
50. Have you ever had a menstrual period?		
51. How old were you when you had your first menstrual period?		
52. How many periods have you had in the last 12 months?		

Explain "yes" answers: _____

_____

_____

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

Signature of Athlete:_____Signature of Parent/Guardian:_____ Date:_____

LAS VEGAS ELITE RUNNERS (LVER)

Pre-Participation Physical Evaluation

PHYSICAL EXAMINATION FORM – *TO BE COMPLETED BY THE PHYSICIAN*

Date of Exam: _____

Athlete Name:_____Sex: ◯ M ◯ F Age:_____ Date of Birth:_____

Height:_____Weight:_____Pulse:_____BP:_____|_____Vision: R 20/___ L 20/___ Corrected: □ Yes □ No

EMERGENCY INFORMATION:

Drug Allergies:_____

Other Information:_____

MEDICAL	Normal	Abnormal Findings
Appearance Marfan stigmata (kyphoscoliosis, high arched palate, peclus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, arotic insufficiency)		
Eyes/Nose/Throat Pupils equal Hearing		
Lymph Nodes		
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) *Consider ECG, echocardiogram and referral to cardiology for abnormal heart history or exam.*		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary / Hernia (males only) *If exam is in a private setting, a third party present is recommended.*		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic *Consider cognitive evaluation or baseline neuropsychiatric testing if history of significant concussion is present.*		
MUSCULOSKELETAL: ROM, Strength	Normal	Abnormal Findings
Neck		
Back/Spine		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional Duck-walk, Single leg hop right Single leg hop left		

□ Cleared for all sports without restriction

□ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

□ Not cleared

□ Pending further evaluation

□ For any sports

□ For Track Events □ For Field Events □ For Cross Country

Reason_____

Recommendations_____

_____

Physician: I certify that I have examined the above-named athlete and completed the Pre-Participation Physical Evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical examination and medical history is on record in my office and can be made available to the LVER staff at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and parents/guardians. I also certify that I am a licensed medical physician, physician's assistant, or nurse practitioner.

Name of physician: (print/type/stamp) _____Date: _____

Address: _____Phone:_____

Signature of Physician:_____